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A MUDANÇA NARRATIVA EM TERAPIA FOCADA NAS EMOÇÕES: A COCONSTRUÇÃO DE NARRATIVAS DO *SELF* INOVADORAS

RESUMO

Segundo a perspetiva narrativa, a psicoterapia deve proporcionar a elaboração de novas experiências e de narrativas inovadoras face às narrativas inflexíveis e constritoras que os clientes usualmente apresentam no início do processo (e.g. Angus & McLeod, 2004; White & Epston, 1990). A noção de momentos de inovação (MIs) abrange estas novidades narrativas que aparecem como exceções às narrativas problemáticas (e.g. novas ações, sentimentos, pensamentos ou intenções; Gonçalves, Matos & Santos, 2009). Segundo esta premissa, Gonçalves, Matos e Santos (2009) desenvolveram o Sistema de Codificação dos Momentos de Inovação (SCMI – Gonçalves et al., 2011) que distingue 5 tipos de MIs (ação, reflexão, protesto, reconceptualização e desempenho da mudança) exibidos por clientes de terapia narrativa (TN – Matos et al., 2009). Depois deste estudo inicial, Gonçalves e colaboradores começaram a questionar se outros modelos de terapia poderiam suscitar a emergência de MIs, apesar de não estarem explicitamente focados na promoção da mudança narrativa (e.g. Terapia focada nas emoções/EFT – Mendes et al., 2010; Terapia centrada no cliente – Gonçalves, et al., 2011; Terapia construtivista – Alves et al., no prelo). Os resultados destes estudos indicam que a elaboração de MIs também ocorre noutras modalidades terapêuticas e evidenciam o importante papel da reconceptualização na distinção do sucesso terapêutico face ao insucesso (Gonçalves, Mendes et al, 2009; Matos et al., 2009; Mendes et al., 2010). Assim, tornou-se pertinente estudar intensamente como são desenvolvidos em terapia os MIs de reconceptualização. Dois aspetos são característicos: (a) o cliente reconhece um contraste no *self*, descrevendo-se como diferente do que era e (b) explica o processo de mudança. Como os estudos anteriores enfatizam sempre a mudança narrativa segundo a perspetiva do cliente, surgiu também a necessidade de compreender as contribuições do terapeuta. Deste modo, reanalisámos os dados de Mendes et al. (2010) de uma amostra de seis clientes deprimidos seguidos em EFT (*York I Depression Project* – Watson & Greenberg, 1998) e iniciou-se o conjunto de estudos sistemáticos desta dissertação. Os nossos objetivos eram: (1) compreender a transição para a reconceptualização e (2) os contributos dos terapeutas para a promoção da

mudança narrativa em EFT. O primeiro estudo utiliza o HSS (*Helping skills system* – Hill, 2009) e o SCMI para explorar as intervenções terapêuticas (focadas na exploração, *insight* e ação) relacionadas com a ocorrência de MIs nestes casos de EFT. Os resultados indicam que todas as intervenções terapêuticas aparecem mais associadas a MIs nos casos de sucesso que nos de insucesso. As intervenções focadas na exploração e no *insight* aparecem associadas à ocorrência de MIs de ação, reflexão e protesto nas fases iniciais e intermédias da terapia e depois associadas aos MIs de reconceptualização e desempenho da mudança na fase final. As intervenções focadas na ação aparecem associadas aos MIs de ação, reflexão e protesto em todas as fases de EFT. O segundo e terceiro estudos focam-se em 3 casos de sucesso terapêutico, explorando intensamente nas sessões a transição para a reconceptualização e as contribuições terapêuticas para este processo. Os resultados mostram que a mudança narrativa não é linear e que esta transição pode ser bastante ambivalente. Além disso, a recursividade da reconceptualização em terapia permite a diferenciação qualitativa destas narrativas. Por sua vez, os terapeutas focam-se no desenvolvimento de uma metaposição (Leiman, 2004) nos clientes, que permite a resolução da ambivalência e a renovação de narrativas do *self*. O quarto estudo explora a diversidade de reconceptualização segundo a escala de assimilação de experiências problemáticas (EAEP – Stiles, 1999, 2001). A análise dos 108 MIs de reconceptualização presentes nesta amostra evidenciou que a maioria foi codificada entre os níveis 4 a 6 da EAEP. A mediana dos níveis da EAEP destes MIs é maior no grupo de sucesso terapêutico (face ao insucesso) e vai aumentando do início ao fim da terapia. O quinto e último estudo investigou o processo que vai da reconceptualização de um problema até à reorganização narrativa do *self* em EFT, através do método de *task analysis* (Greenberg, 2007). Seguindo um foco na díade terapeuta-cliente, o modelo racional-empírico descobriu 9 passos sucessivos: 1) Reconhecimento explícito de diferenças no presente e passos em direção à mudança; 2) Emergência de uma meta-perspetiva que contrasta o *self* no passado e presente; 3) Amplificação do contraste; 4) Apreciação positiva das mudanças; 5) Sentimentos de competência, mestria e autonomia, acompanhadas de validação terapêutica; 6) Referência a dificuldades ainda presentes; 7) Perda de centralidade dos problemas; 8) mudança como um processo gradual, em desenvolvimento; e 9) Novos planos, projetos e experiências de mudança. Por fim, os resultados dos diferentes estudos são integrados numa discussão final segundo 3 focos: cliente, terapeuta e diádico (Elliott, 1991).

NARRATIVE CHANGE IN EMOTION-FOCUSED THERAPY: CO-CONSTRUCTING INNOVATIVE SELF-NARRATIVES

ABSTRACT

According to the narrative framework, clients seek therapeutic help due to the constricting nature of problematic self-narratives and psychotherapy should contribute to the elaboration of new experiences and innovative self-narratives (e.g. Angus & McLeod, 2004; White & Epston, 1990). The notion of innovative moments (IMs) refers to these narrative novelties, which appear as exceptions to the clients' problematic self-narratives (like new actions, feelings, thoughts or intentions; Gonçalves, Matos & Santos, 2009). According to this view, Gonçalves, Matos and Santos (2009) developed the Innovative Moments Coding System (IMCS; Gonçalves et al., 2011), which differentiates five types of IMs (action, reflection, protest, reconceptualization and performing change) exhibited by clients in a sample of narrative therapy (NT; Matos et al., 2009). After these initial research studies, Gonçalves and collaborators (Matos, et al., 2009) began wondering if IMs would appear in sessions from other therapy models that were not explicitly focused on the promotion of narrative change (e.g. emotion-focused therapy or EFT – Mendes, et al., 2010, 2011; client-centered therapy – Gonçalves, Mendes, et al., 2011; constructivist therapy – Alves et al., in press). Findings from these studies indicate that the elaboration of IMs also occurs outside NT and consistently evidence an important role of reconceptualization as a marker of good outcome in the contrast with poor outcome therapy (Gonçalves, Mendes et al, 2009; Matos et al., 2009; Mendes et al., 2010). Therefore, it became important to intensively investigate how these IMs are developed in psychotherapy. Two important features characterize reconceptualization IMs: (a) the client recognizes a contrast in the self, describing oneself as different and (b) explains how the transformation process happened. Furthermore, the previous studies highlighted narrative change from the perspective of the client and there was the need to understand therapists' contributions. We took the findings from Mendes et al. (2010) on a sample of six EFT clients drawn from the York I depression project (Watson & Greenberg, 1998) and began a set of systematic studies presented in this dissertation. Our purposes were to understand (1) the transition to reconceptualization and (2) the therapist' contributions in the promotion of narrative change in EFT. The

first study uses the helping skills system (Hill, 2009) and the IMCS to explore the therapist skills (exploration, insight or action) related to the occurrence of IMs in the six EFT cases. Results show that all skills appear more associated to IMs in good than in poor outcome cases. Exploration and insight skills appear more associated to the occurrence of action, reflection and protest IMs in the initial and middle phases of therapy and then appear more associated to reconceptualization and performing change in the final phase of therapy. Action IMs appear more associated to action, reflection and protest IMs throughout all EFT phases. The second and third studies focus on three good outcome cases, exploring intensively within sessions the transition to reconceptualization and the therapists' contributions for this process. The findings show that narrative change is not linear and that this transition can be quite ambivalent. Thus, the recursivity of reconceptualization IMs throughout therapy leads to a qualitative differentiation of these narratives. The therapists are focused on the development of a metaposition (or observer position – Leiman, 2004) in the client, which allows the resolution of ambivalences and the renewal of new self-narratives. The fourth study explores the diversity of reconceptualization IMs according to the assimilation of problematic experiences scale (APES – Stiles, 1999, 2001). The analysis of the 108 reconceptualization IMs appearing in this EFT sample evidenced that the majority were coded with APES levels 4 to 6. The median APES levels of reconceptualization IMs were higher in the good outcome group (in relation to poor outcome), and kept increasing until the end of EFT. The fifth and last study explored the process that unfolds from the reconceptualization of a problem to the narrative reorganization of the self in EFT, through the method of task analysis (Greenberg, 2007). Following a focus on the client-therapist dyad, the rational-empirical model discovered nine necessary steps: 1) Explicit recognition of differences in the present and steps in the path of change; 2) Emergence of a meta-perspective contrast between present self and past self; 3) Amplification of contrast in the self; 4) Positive appreciation of changes; 5) Feelings of empowerment, competence and mastery, accompanied by therapist validation; 6) Reference to difficulties still present; 7) Loss of centrality of the problem; 8) Change as a gradual, developing process; and 9) New plans, projects or experiences of change. Central aspects of therapist activity in facilitating the client's progression in this process are also elaborated. Finally, the several findings from the five studies are integrated in a discussion according to three *foci*: client, therapist and dyadic focus (Elliott, 1991).

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INTRODUCTION

INTRODUCTION

Emotion moves us and reason guides us.
(Leslie Greenberg, 2008, p. 50)

This dissertation is a collection of interrelated studies carried out within the Innovative Moments research group at the University of Minho (Portugal), from September 2007 to September 2011. In order to better understand this research work and its evolution, I will use this introduction section as an opportunity to globally frame the field of psychotherapy process research and in particular the research conducted on innovative moments.

This introduction is divided in four sections. The first section will provide an overview of psychotherapy change process research and emotion-focused therapy for depression. This section will begin with a brief characterization of the field of psychotherapy research and proceed to elaborate specifically distinct methodological approaches to the study of change processes. A second section will characterize the emotion-focused therapy (EFT) for depression, given that this is the treatment in focus throughout the several studies presented in the following chapters. This overview on EFT will include an elaboration of this treatment's core assumptions and therapeutic guiding principles as well as the emotion-focused relational stance. The findings and theoretical contributions deriving from the Innovative Moments research group will be the target of the third section of this introduction. This section will present a detailed summary of the different studies previously carried out within this framework along with its proposals for the understanding of narrative change and stability in psychotherapy. Finally, the fourth and last section of this introduction will present the several aims and research questions that motivated the following five studies, preparing the reader for the succeeding chapters.

PSYCHOTHERAPY RESEARCH AND THE STUDY OF CHANGE PROCESSES

In the study of psychotherapy, there is usually a distinction between *process* and *outcome research* (Pachankis & Goldfried, 2007). According to Hill and colleagues (Hill & Corbett, 1993; Hill & Lambert, 2004), *process research* is usually concerned with "what happens *in* psychotherapy sessions in terms of therapist behaviors, client behaviors, and the interaction between therapists and clients" (Hill & Corbett, 1993, p. 3). In contrast, *outcome research* usually concentrates on changes that occur in psychotherapy as a product of its evolution, given the results of pre and post-treatment assessments (Hill & Lambert, 2004). The contrast between these assessments is typically evaluated with measures that capture the evolution of client symptoms and allow the categorization of good and poor outcome therapy (good outcome or GO – in case of significant symptom remission and poor outcome or PO – in the absence of significant symptom remission; this distinction can be referred to as big-O outcome). Traditionally, outcome research has been interested in the study of the efficacy of specific treatments conceived for certain clinical diagnosis, for which the randomized, controlled clinical trial is the golden standard (Ablon & Marci, 2004; Barber, 2009; Kopta, Lueger, Saunders, & Howard, 1999). However, this distinction between outcome and process research can sometimes become blurred, as some studies may treat process measures as in-session immediate or intermediate outcomes of psychotherapy (small-o outcomes; Hill & Corbett, 1993; Hill & Lambert, 2004).

Nevertheless, the last four decades have been characterized by a renewed and growing interest on psychotherapy process research (Hill & Lambert, 2004; Goldfried, Greenberg & Marmar, 1990; Hill & Corbett, 1993; Pachankis & Goldfried, 2007). Several authors pinpoint different reasons to justify this increasing focus on process:

(1) A growing disenchantment with the findings deriving from outcome research, focused on randomized clinical trials (Ablon & Marci, 2004; Barber, 2009; Hill & Corbett, 1993; Hill & Lambert, 2004), particularly regarding their (lack of) application to "real" practice with "real" people in more naturalistic settings, and the (sometimes controversial) findings regarding the efficacy of differential psychotherapies (Pachankis & Goldfried, 2007; Stiles, Barkham, Mellor-Clark, & Connell, 2008; Stiles, Shapiro, & Elliott, 1986) or the idea that simple pre–post

outcome designs often do not adequately portray the shape of change, acknowledge mediators and moderators of change and the best timing for the application of specific interventions and techniques (Pachankis & Goldfried, 2007);

(2) The need to produce significant knowledge for psychotherapy practice, in the attempt to surpass criticisms regarding the lack of relevance of research findings for practicing clinicians (Barber, 2009; Hill & Corbett, 1993; Pachankis & Goldfired, 2007);

(3) An increasing popularity of qualitative, naturalistic methods in psychology, also applied to psychotherapy research, which facilitated the more articulate integration of data and findings deriving from outcome studies (Goldfried, Greenberg & Marmar, 1990; Hill & Corbett, 1993; Hill & Lambert, 2004; Morrow, 2007; Pachankis & Goldfried, 2007);

(4) The improvement of process research methods (particularly aided by advances in computer technology and data analysis software solutions) that surpass "the proliferation of trivial studies" from the early wave of process research (Hill & Corbett, 1993, p. 14).

The previous conditions have set the momentum for a systematic collective effort of researchers that, while studying the psychotherapy process, are particularly interested in *change process research* (CPR – Greenberg, 1986, 1991; Elliott, 2010).

> With processes of change as the focus of investigation, the emphasis is not on studying what is going on in therapy (process research) nor only on the comparison of two measurement points before and after therapy (efficacy research) but rather on identifying, describing, explaining, and predicting the effects of the processes that bring about therapeutic change over the entire course of therapy. (Greenberg, 1986, p. 4)

In another view, Kopta and colleagues (1999) refer that this type of research aims for the identification of the active ingredients of psychotherapy and mechanisms or principles of change so that greater control can be obtained in the effective design and delivery of therapeutic interventions. Therefore, as Greenberg (1991) put it, change process researchers have been attempting to tackle some of the "unanswered questions" and "unquestioned answers" (p. 3) in psychotherapy, hoping to realize the

promise of this research field (Elliott, 2010). This new, highly productive wave of process research is characterized by a multiplicity of research methods, which will now be discussed. These methods represent an increasing effort to overcome the limitations of randomized clinical trials and efficacy research, complementing them in the refinement of global findings and in the approximation to the clinical phenomena of interest, in a more straightforward link to the production of relevant implications for psychotherapy practice and theoretical knowledge (Pachankis & Goldfried, 2007).

Different methodological approaches to change process research

In a recent review on research methodology carried out by Elliott (2010), this author suggests the following approaches to change process research: (1) the quantitative process-outcome design; (2) the qualitative helpful factors design; (3) the microanalytic sequential process design; (4) theory-building case studies and (5) the significant events approach. Although this author aggregated theory-building case studies within the significant events approach, we decided to develop these designs separately to provide further detail.

1. Quantitative process-outcome designs. Globally, this research design involves sampling key processes, from one or more sessions, which are used to predict (good and poor) outcome, in order to determine the contribution of specific mechanisms of change or mediators to the overall distinction between outcome groups (Elliott, 2010). It usually combines qualitative and quantitative data analysis. According to Elliott (2010), this is the most popular research design because it is easy to understand and widely accepted in publications; however, its limitations may concern measurement, sampling and internal validity problems, creating a (sometimes wide) gap between the process that is measured and the final outcome that it aims to explicate.

In a more salient critique, Stiles and Shapiro (1989, 1994) have been stressing that this type of research is associated with a sometimes implicit or explicit *drug metaphor*: the idea that, such as within the medical model of research, the impact of psychotherapeutic interventions can be tested like the action of specific drugs are tested for a given clinical condition (i.e. in terms of active therapeutic ingredients that are provided in certain doses/amounts to clients). These authors raised several philosophical critiques for this conceptualization (Stiles & Shapiro, 1989), from

which we select three: a) unlike drugs, psychological interventions are all about meaning that is co-constructed by clients and therapists, taking into account a given context, past experiences and their idiosyncratic meaning systems; b) an adequate description of a given intervention must be aligned philosophically with the theory from which it derives; c) the medical model is grounded on philosophical conceptions of health and disorder that can be quite contrasting with the theory and practice of psychological interventions. Later on, the same authors (Stiles & Shapiro, 1994) drew attention to the fact that the correlation logic of process-outcome designs overlooks therapist and client's *mutual responsiveness*, in terms of what participants require from and do to match each others cues and needs at specific interactional moments (Stiles, Honos-Webb & Surko, 1998). This process provides always changing situational adjustments, which "implies that outcome feeds back to influence process" (Stiles & Shapiro, 1994, p. 946). Since feedback is characteristic of human interaction, the process-outcome system is non-linear, which means that conventional statistics – usually based on linear models – are likely to misrepresent the therapeutic process (Stiles & Shapiro, 1994; Elliott, 2010).

However, Silberschatz (1994) replies that these problems can be overcome with carefully considered internally valid measures and data analysis methods. Currently, increasingly sophisticated analytic methods have been trying to address these issues and surpass some of these limitations (Barber, 2009; Elliott, 2010). Furthermore, several authors currently defend that process-outcome studies have much to offer to psychotherapy research when (i) they are used to test well-developed hypothesis and/or theories (Elliott, 2010), (ii) they adopt a multifaceted approach (multiple methods and multiple measures – Barber, 2009), and (iii) attempt to provide evidence for the effects of key outcome mediators and moderators (Kendall, Holmbeck & Verduin, 2004; Pachankis & Goldfried, 2007).

2. Qualitative helpful factors design. This research design involves the study of client perceptions about what they found helpful or unhelpful in therapy, through research interviews and/or self-report questionnaires during the psychotherapy process (e.g. following specific sessions) or after therapy termination (Elliott, 2008, 2010). These rich, personal accounts are then usually studied through a variety of qualitative methods, like grounded analysis (Fassinger, 2005; Strauss & Corbin, 1998) or consensual qualitative research (Hill, et al., 2005).

One of such examples is an empirical taxonomy of helpful and nonhelpful events developed by Elliott (1985; this author is one of the strong advocates for this type of research) that was later used as a measure to analyze the impact of these events in therapy sessions (Elliott, et al., 1985). Along these lines, Henkelman and Paulson (2006) also carried out more recently an exploration of hindering experiences in psychotherapy using the qualitative helpful factors design. Another example of a measure that was initially developed through a grounded analysis of client interviews is the Pausing Inventory Categorization System, created by Levitt (2001), and later on applied in a process-outcome study (Frankel, et al., 2006). A recent special issue on *Psychotherapy Research* (Elliott, 2008) evidences how this approach is creative and dynamic.

Despite some criticisms that client reports may sometimes be inarticulate, untrusting or even misleading sources of information, this approach is becoming more appealing for researchers who are especially interested in the client perspective on psychotherapy process (Elliott, 2010; Hill & Lambert, 2004; Macran et al., 1999). Such data can be used as an information source complementing other types of research (e.g. intensive case studies or randomized clinical trials). In addition, the research findings can be used for the development of measures or theories departing from the client perspective and also lead to mental health services improvement (Elliott, 2010; Macran et al., 1999).

3. Microanalytic sequential process designs. This approach focuses on the turn-to-turn conversation between therapist and client, coding their responses according to previously established categories or rating scales (Elliott, 2010). This type of research is among the earliest process research that emerged in the 1940s (e.g., Snyder, 1945) and lead, for example, to the categorization of therapist skills (also known as verbal actions or verbal response modes), in the attempt to answer research questions such as: "What client processes are triggered by what therapist responses under what conditions?" (Elliott, 2010, p. 128). These research efforts aimed, for example, to understand how particular therapist interventions were linked with specific therapeutic modalities (e.g. Hill, Thames & Rardin, 1979; Stiles, Shapiro & Firth-Cozens, 1989), which interventions would be more helpful for therapeutic outcome (e.g. Hill, Carter & O'Farrel, 1983) or for the establishment of an empathic

therapeutic alliance (Barkham & Shapiro, 1986; Fitzpatrick, Stalikas, & Iwakabe, 2001).

Although remaining very popular until the 1980s, with more than 30 different therapist category systems being developed (e.g., Elliott, et al., 1987; Hill, 1978; Stiles, 1979), the disenchantment with this type of research grew stronger and these studies are now less common in comparison to other approaches (Elliott, 2010). Some of the criticisms were especially directed to studies that aimed to verify the impact of specific skills (e.g. helpfulness of therapist interpretation) in the overall therapy outcome: it certainly is a large leap to try to link specific (micro)skills used in the session to a prediction of (macro) therapy outcome (Elliott, 2010). For this reason, Elliott et al. (1985) recommended that this line of research should maintain a focus on *immediate therapeutic impacts* – i.e., the therapeutic effect which specific therapist responses bring about in clients during their delivery or shortly afterward. Other criticisms regard the cumulative effect that interventions have: a given intervention may have a specific immediate impact not only because it was used at that moment, but because others were also used immediately before (in what is called a "lag 1" sequence in time-series analysis – Elliott, 2010). Moreover, therapists may also be manifesting a certain degree of responsiveness to the clients' needs while using a particular intervention in context. In other words, the therapist's choice may be a reaction to the immediate feedback received from the client (*mutual responsiveness* – Stiles, et al., 1998).

Nevertheless, in psychotherapy it is assumed that what therapists say, and how they say it, has the goal of influencing the client in a beneficial manner (De Stefano, Bernardelli, Stalikas & Iwakabe, 2001). Several authors still find it reasonable to study the impact of the therapist in the client (De Stefano, Bernardelli, Stalikas & Iwakabe, 2001); however, this can be more useful and clarifying if the therapist and client variables under research are kept within the same level of analysis and if attention is drawn into immediate outcomes (Elliott et al., 1985). In this line of reasoning, the microanalytic sequential process design has been successfully applied to the analysis of therapist interventions that precede client laughter (Falk & Hill, 1992), good-moments in short-term dynamic therapy (De Stefano, et al., 2001), diverse client narrative process modes in an initial stage of therapy (Goates-Jones, 2004) and high client involvement in the session (Kasper, Hill & Kivlighan, 2008), to name a few examples.

4. Theory-building case studies. Theory-building case studies are a special type within case study research (Aveline, 2005; Hill & Corbett, 1993; Iwakabe & Gazzola, 2009). The aim of this research design is mainly to depart from the unique features of particular cases to challenge, refine and improve preexisting theories (Stiles, 2007). For this, usually the focus stays very close to the phenomena (e.g. therapeutic transcripts), examining intensively how if unfolds in time and privileging concreteness, explicitness and thick descriptions (Elliott, 2010; Stiles, 2007). Therefore, these studies are highly contextual, idiographic and hermeneutic, which makes them one of the most appealing practice-oriented designs (Aveline, 2005; Iwakabe & Gazzola, 2009; Stiles, 2007).

Through this correspondence between theory and observations, this type of research can actually be used to challenge the accuracy of theories and refine or develop new hypothesis about the phenomena, which were not captured yet by the theory in its current state of development (Stiles, 2007). Thus, the goals here are typically to explore and enrich, in opposition to the testing of hypothesis (which can be done in experimental case studies or N=1 studies, also known as single participant design research; Iwakabe & Gazzola, 2009) or confirming theoretical statements (typical of clinical case studies – Iwakabe & Gazzolla, 2009; Stiles, 2007). Having these goals while approaching the case, researchers tend to privilege the intensive analysis of significant change events and discovery is usually an important element of this type of studies (here we acknowledge the connection with the significant events approach, highlighted by Elliott, 2010). The significant events are selected through a theoretical sampling procedure (Eisenhardt & Graebner, 2007) – that is, they are intentionally chosen by researchers due to their suitability for the demonstration of an important aspect or process.

However, this brings issues of generalizability into consideration: how much can we rely on a single case? According to the literature on the field, a theoretical hypothesis deriving from a case study has to be considered tentative and idiographic and lead researchers to proceed to other studies in order to build increasing confidence in that theoretical sentence (Iwakabe & Gazzola, 2009; Stiles, 2007). This can be done afterwards through hypothesis testing designs (Elliott, 2010) or through a systematic analysis of other case studies, also known as a meta-synthesis of case studies (Iwakabe & Gazzola, 2009). A meta-synthesis is a study that tries to aggregate

and compare the findings deriving from several case studies dealing with the same clinical issues, in order to identify similar processes (Iwakabe & Gazzola, 2009). It stands for qualitative research as meta-analysis stands for quantitative research (see Iwakabe & Gazzola, 2009 for further details). This means that through a persistent, comparative effort of analyzing different cases, a theory can be built, refined and/or changed because each case provides further degrees of confidence in the theory (Iwakabe & Gazzola, 2009; Stiles, 2007). An example of this systematic research program is the assimilation model developed by Stiles and collaborators (Caro-Gabalda, 2008; Honos-Webb & Stiles, 1998; Osatuke & Stiles, 2006; Stiles, et al., 1990; Stiles, 1999) or the hermeneutic single-case efficacy design (Elliott, 2002).

5. Significant events approach. This approach combines several designs focused on a discovery-oriented, interpretive and theory-building framework for change process research, like task-analysis and comprehensive process analysis (Elliott, 2010; Greenberg, 1991). According to Elliott (2010), research designs within this approach share three key aspects: 1) the establishment of specific strategies to identify significant change events in psychotherapy (akin to theoretical sampling – Eisenhardt & Graebner, 2007); 2) after gathering a sample of significant events, researchers develop a sequential, qualitative description of the change process by tackling the simultaneous, multiple dimensions for its unfolding (i.e. thick descriptions) and arriving at a theoretical model; 3) theoretical models are then tested through process-outcome designs to assess their predictive value when relating process to outcome. Given these aspects, the possibility to bring innovative contributions to the field while simultaneously producing practice-relevant knowledge are among the most appealing features of these designs, despite the long and demanding process that they usually imply (Elliott, 2010; Greenberg, 1991).

In our view, these designs can be distinguished from theory-building case studies in two essential characteristics. First, the significant events approach implies always the systematic comparison across cases while most of the theory-building case studies do not. Second, although a theory-building single case study can contribute with the discovery of one or two ideas as hypothesis to challenge or develop a preexisting theory, the significant events approach is more ambitious since it frequently aims for a more developed, coherent and substantial theoretical contribution (i.e. the sequential description of a change process developing).

We will now focus on the method of task-analysis, since it is one of the most well known designs within this approach and is particularly pertinent for the present work. According to Greenberg (2007), task-analysis is a methodological procedure that was developed in the 1940's to discover information-processing components involved in a complex task. It was initially used mainly in cognitive and work psychology (e.g. the task-analysis of assertive behavior – Schwartz & Gottman, 1976). Nevertheless, since the 1970's, it has been successfully applied in the field of psychotherapy research.

One of the pioneers in this application of task-analysis to the study of significant in-session change events was Greenberg (1984, 1986, 2007), working in collaboration with several colleagues (Greenberg & Foester, 1996; A. Pascual-Leone, Greenberg & J. Pascual-Leone, 2009; Rice & Greenberg, 1984). Since its introduction in psychotherapy research, this research strategy has helped to highlight client processes involved in the successful resolution of several tasks in individual emotion-focused therapy, such as inner-conflict resolution (cf. Greenberg, 1983); unfinished business (Greenberg & Foerster, 1996; Greenberg & Malcolm, 2002), creation of meaning (Clarke, 1989, 1996) and emotional processing events (Pascual-Leone & Greenberg, 2007a).

However, task-analytic studies can have different *foci*: they can highlight client performance (when emphasizing client process), therapist performance (when emphasizing therapist activity) or dyadic performance (when drawing attention to dyadic interaction as a whole). Consequently, this design has also helped to differentiate productive dyadic activity for the resolution of in-session ruptures in the therapeutic alliance during integrative psychotherapy (Safran et al., 1990; Safran & Muran, 1996) and psychodynamic-interpersonal psychotherapy (Agnew, Harper, Shapiro & Barkham, 1994) and also for dealing with alliance-threatening transference enactments in cognitive-analytic therapy (Bennett et al., 2006).

Task analysis is usually applied within a research program requiring a series of different studies to discover and validate the processes that occur in the resolution of specific cognitive-affective problems, events or experiences in psychotherapy (Greenberg, 1986, 1991, 2007; A. Pascual-Leone, Greenberg & J. Pascual-Leone, 2009). According to Greenberg (2007), task analysis involves two general stages: the discovery phase and the validation phase. In addition, the discovery phase involves two main landmarks: a) the construction of a rational model and b) the establishment

of a rational-empirical (i.e. both theoretical and empirical) model of the change process.

In the first phase (discovery-oriented), researchers need to carry out the following analytic steps (Aspland et al., 2008; Greenberg, 1986, 2007; A. Pascual-Leone, Greenberg & J. Pascual-Leone, 2009):

1) Define a specific therapeutic task that is going to be investigated and operationalize its markers, namely its beginning and end points. A *task* is a particular in-session change event that needs to be defined as an affective-cognitive problem characterized by specific discursive, behavioral and/or affective indicators.

2) State the researcher's assumptions and expectations involved in ideal resolution. At this point, researchers have to state their cognitive map when approaching the task, which compels to identify previous assumptions and perspectives concerning the event and its resolution. Instead of viewing researchers preconceptions as biased, this design capitalizes on previous clinical impressions or hypothesis that were formulated through the researchers' clinical experience of dealing with the event in therapy (A. Pascual-Leone, Greenberg & J. Pascual-Leone, 2009).

3) Define task context/environment. Here researchers specify and describe the context where the task occurs and from where it derives its specificity, which will later on allow for the replication and validation of findings in similar settings.

4) Depict a rational model of the task (i.e. rational analysis). The combination of this explicit cognitive map and the analysis of clinical examples (three "good performances" and three "poor performances") allows researchers to construct a rational model of task resolution, conjecturing the hypothetical steps required for a successful performance. This rational model tries to answer the question: *How do I think clients resolve this particular task?* and acts as a baseline towards the next discovery steps in task analysis. With this first landmark achieved, the empirical analysis is initiated.

5) Contrast the rational model with the analysis of actual performances and synthesize a rational-empirical model (i.e. empirical task analysis). This is considered the core of the discovery phase of task analysis (Greenberg, 2007). At this point, researchers (usually working in pairs) need to contrast the hypothetical, rational model against real performance, through the analysis of further in-session events that are selected through a theoretical sampling strategy. Each event may lead to the

refinement of the model through deletion, alteration and addition of essential steps, until *saturation* is reached (i.e. new episodes do not lead to further changes). The model is then synthesized through a flow diagram, exhibiting the essential steps/components necessary for successful task completion. Also important at this point is the development of measures for each step of the model that will permit subsequent validation. These measures are also a product of the discovery-oriented phase (A. Pascual-Leone, Greenberg & J. Pascual-Leone, 2009).

The next stage of task-analysis is called the validation phase. It is now concerned with generalizability issues and the testing of hypothesis raised by the discovered rational-empirical model (Greenberg, 2007; A. Pascual-Leone, Greenberg & J. Pascual-Leone, 2009). This stage comprises the following essential steps:

1) Validate the components of the model. First, new events are selected and categorized as "resolved" and "non-resolved" performances by clinical judges, familiarized with the rational-empirical model. Then, trained judges who are not aware of the "resolved or non-resolved" status of events, by taking into account the established markers, independently code this new sample. This is done to check if this categorization can be achieved with a satisfactory level of reliability through inter-judge assessment.

2) Relate process to outcome. This is a hypothesis-testing study that checks if the presence of resolved events (i.e. composed by the steps that indicate task resolution), when contrasted with the presence of non-resolved events, can predict good outcome therapy.

3) Explore sequential structures through quantitative dynamic modeling. This is a new step to task-analysis introduced by A. Pascual-Leone (2009) that aims to verify if the sequential ordering of the rational-empirical model is confirmed through a new hypothesis-testing study, which uses more sophisticated data analysis to capture sequentially patterned data (e.g. nonlinear micropatterns of change – A. Pascual-Leone, Greenberg & J. Pascual-Leone, 2009).

EMOTION-FOCUSED THERAPY IN FOCUS

We will now concentrate on emotion-focused therapy (EFT) for depression in more detail, since this is the treatment in focus throughout the studies presented in the subsequent chapters. We will begin by characterizing this modality through an elaboration upon: (1) its core assumptions, (2) the underlying emotion theory and principles, (3) the EFT relational environment and, finally, (4) the therapeutic tasks for depression.

Basic assumptions of EFT

Emotion-focused therapy (EFT – Greenberg, 2002, 2004, 2006, 2008) or, alternatively, process-experiential therapy (PE – Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg, Rice, & Elliott, 1993) is an empirically supported treatment (Elliott, Greenberg & Lietaer, 2004) that places emotion at the core of human functioning, its relational and meaning-making processes and also psychotherapeutic change. This treatment modality originated from the humanistic-experiential tradition, conciliating the client-centered relationship stance (Rogers, 1951, 1957) with therapeutic tasks originated from gestalt therapy (Perls, Hefferline, & Goodman, 1951) and focusing-oriented psychotherapy (Gendlin, 1996).

EFT views emotions as fundamental to the construction of the self and self-organization processes, since they signal the significance of a situation and provide a *gut level* (visceral) immediate source of information (a pre-conscious evaluation of stimuli), that is used by human beings to discern among competing priorities, orient to action and adaptation to environments and promote well-being (Greenberg, 2004, 2008; Greenberg & A. Pascual-Leone, 2006; Greenberg & Safran, 1989). Furthermore, emotion is considered to play an essential role in adaptive and maladaptive human and interpersonal functioning. Consequently, to this form of therapy, therapeutic change is achieved through changing emotion and the abilities to experience, tolerate, symbolize, and express emotions are considered essential to healthy functioning (Greenberg, 2002; Greenberg, Rice & Elliott, 1993; Pos & Greenberg, 2007).

Along with this understanding about emotions, EFT also proposes an underlying constructivist epistemology and theory, referred to as a *dialectical-constructivist* view of human beings (Greenberg & J. Pascual-Leone, 1995, 2001).

According to this perspective, in addition to having emotions as our basic self-organizing and interactional tools human existence is characterized by a constant process of making sense of emotions (Greenberg, 2004). This process is present from early human development, when the interaction with significant others provides regularities in emotional experience that allow the differentiation of complex *emotion schemes* (Greenberg, Rice & Elliott, 1993; Siegel, 1999). Emotion schemes are units of emotional experience stored in memory networks, which originated in phylogenetic development and become differentiated and refined through learning and culture (Greenberg, 2004; Greenberg & J. Pascual-Leone, 1995). These units allow the construction of an implicit "felt sense", which is the earliest, primary source of information babies have on how to orient themselves in the world and towards others (Siegel, 1999). In time, these implicit structures become generalized and automatic, regulating personal experience and human functioning (adaptive or maladaptive – Greenberg, Rice & Elliott, 1993).

Once the acquisition of semiotic tools and language allows it, human consciousness then becomes characterized by this ongoing dialectic between *experiencing* (bodily-felt referents) and *explaining* (i.e. symbolizing and making sense of what is felt) by articulating the three major roots of personal experience: "(a) a conscious, deliberate, reflexive, and conceptual process (thinking); (b) an automatic, direct emotional-experiential process (feeling); and (c) the constructive, dialectical-dynamic interactions between the two" (Greenberg & J. Pascual-Leone, 1995, p. 183).

Emotion theory and principles of emotional change

In the practice of EFT it is important to be able to distinguish between types of emotions, since these provide a map for different interventions (Greenberg, 2004). According to Greenberg (2002), because emotions are not simple, uniform and singular entities, therapists should be able to assess: (a) emotion intensity or avoidance (that is, if client's emotions are over- or under-controlled); (b) emotion productivity (that is, recognize adaptive or maladaptive emotions); and (c) if the emotion is a sign of distress or part of the change process (i.e. a by-product of maladaptive functioning or sign of resolution).

A basic distinction is between *primary* and *secondary emotions* (Greenberg, 2002, 2004; Greenberg, Rice & Elliott, 1993; Greenberg & Safran, 1989). A *primary emotion* is an immediate reaction to a stimulus – like feeling sad when one loses a

significant other – while a *secondary emotion* is a derivative, secondary response to a more basic internal process (such as prior thoughts or primary emotions) – like feeling angry for being sad. Secondary emotions may be related with defenses or culturally-learned scripts (such as gender-related): for example, some men are more prone to becoming angry (secondary emotion) when they feel hurt and sad (primary emotion), whereas some women may feel guilty (secondary) when getting angry at a loved one (primary). In addition, *instrumental emotions* refer to the expression of an emotion with the intention to gain something from other people's response to it (such as crying to gain other people's support). These involve a conscious or unconscious intention to manipulate others.

Another important distinction is between *adaptive* and *maladaptive emotions* (Greenberg, 2002, 2008; Greenberg & Safran, 1989). An *adaptive emotion* is one that allows us to adjust to the environment and maintain personal integrity and growth. For example, becoming angry when one feels that others are being unfair or invading our personal boundaries is usually reasonable and may lead us to assert our needs and values according to socially accepted ways to do it. Alternatively, a *maladaptive emotion* is a learned response that is no longer useful or adaptive (as it usually was in the past) and needs to be regulated and transformed. These are usually familiar feelings that occur repeatedly (e.g. fear of abandonment, sense of inadequacy – Greenberg, 2004). For example, if a client is systematically unable to assert oneself towards a colleague at work due to a history of parental abuse, this indicates that this submissive interpersonal pattern – despite the protection that it may have provided in the past relationship with a violent parent – is no longer functional.

According to EFT (Greenberg, 2002, 2004, 2008), there are basically three empirically supported treatment principles to work with emotion and facilitate emotional change: "(a) increasing awareness of emotion, (b) enhancing emotion regulation, (c) transforming emotion" (Greenberg, 2004, p. 8). Progress in these principles requires the establishment and maintenance of a strong therapeutic alliance that provides the relational environment for the working-through of crucial emotional processes and the transformation of maladaptive emotion schemes (Watson & Greenberg, 1998).

A first step in productive emotional work involves *awareness of emotions* – particularly of primary adaptive emotions – and being able to label and symbolize them (articulating in words). This is important to access the underlying action

tendency – or core *need* – that is used to inform and move the person (for example, sadness drives for contact with others). Symbolization here is more than mere reflection about emotions (Greenberg, 2004). It means that an emotion must first be *felt* – that is, activated, approached, tolerated and accepted – and only then articulation through language becomes an important component and the access to core needs and action tendencies becomes a possibility. If emotions are initially avoided, specific procedures to activate and process them are needed (e.g. changing preconceptions about the importance of emotions, tolerating emotional arousal and expression etc.).

A second step in working with emotions implies *emotion regulation* (Greenberg, 2002, 2004). Useful skills involved in emotion regulation are: (a) identifying emotions and labeling them through language; (b) allowing and tolerating emotional arousal and expression; (c) establishing a working distance and preventing enmeshment with disruptive, negative emotions; (d) reducing vulnerability to negative emotions while increasing positive emotions; (e) self-soothing; and, (f) distraction (Greenberg, 2008). Emotion regulation in therapy requires a strong therapeutic bond and a safe, validating environment, along with a sharp and attuned understanding from therapists concerning which emotions are important to focus and their intensity (moment-by-moment *process diagnosis*; Greenberg, 2004). For example, clients who avoid certain emotions due to cultural scripts (e.g. primary anger) often benefit from therapist validation (recognizing, accepting, and legitimating that anger) in order to strengthen the self; alternatively, clients with under-controlled secondary emotions (e.g. explosive anger) benefit from therapist validation and learning emotion regulation skills (to cope more efficiently with anger and express it more adaptively) along with the access to core needs and primary emotions (that will allow to resolve their distress).

A third, final step of *emotion transformation* requires changing emotion with emotion (Greenberg, 2002; Greenberg & A. Pascual-Leone, 2006). This principle means that the overall goal of EFT is to change maladaptive emotions by coupling or undoing them with more adaptive, positive emotions (Greenberg, 2002, 2004, 2008). In practice, this requires the activation of a maladaptive emotion and the co-activation of a more positive, adaptive emotion along with or in response to it, promoting psychological resilience (e.g. the activation of fear and subsequently of empowerment). In time, the maladaptive emotion will be experientially transformed

due to the access and contact with the adaptive emotion (Greenberg, 2008). This principle is in clear divergence with the assumption of other therapies that it is possible to change emotion through reason or cognitions (such as cognitive-behavior therapy – Beck, Rush, Shaw, & Emery, 1979). Moreover, it goes beyond emotion catharsis or completion, exposure, habituation or extinction, since the idea is not to purge or attenuate the feeling, but rather transform, replace or undo it (Greenberg, 2004; Greenberg & A. Pascual-Leone, 2006). Some examples of therapeutic strategies to transform emotions are: access core needs and goals, creation of a new meaning, enactment of the emotion (Greenberg, 2004; see Greenberg, 2002, for further details).

According to A. Pascual-Leone and Greenberg (2007b), working through these principles leads to the development of *experiential insight*, which values two aspects: (a) increased *awareness* and *owing* (i.e., discovery, integration and expansion of personal experience) and (b) amplified *meta-awareness* (i.e. perceiving, symbolizing, and understanding of emotional experience). This kind of insight – i.e. more *experience-near* – brings the individual closer to his/her own experiencing and can be distinguished from other forms (traditionally more conceptual and abstract – i.e. *experience-distant*) which are more commonly addressed in other therapeutic schools. The end result is deep-experiential knowledge (Pos & Greenberg, 2007) because "What we make of our emotional experience makes us who we are." (Greenberg, 2008, p. 53).

The EFT relational stance and therapeutic skills

Since the experiential work is so complex, the therapeutic relationship (and working alliance) is considered very important for the creation of a productive environment (Pos & Greenberg, 2007). As we have noted earlier, the EFT therapeutic relationship integrates a humanistic, client-centered relational stance with the more active and directive interventions drawn from other experiential therapies (Greenberg, 2002, 2006; Greenberg, Rice & Elliott, 1993). For the client-centered tradition, the therapeutic relationship is the primary vehicle of change (Watson & Greenberg, 1998). Rogers proposed that therapists must provide a safe environment, embodying and communicating empathic attunement, unconditional positive regard, prizing and congruence in the relationship (*the necessary and sufficient attitudes for client change* – Rogers, 1957). It was expected that through a strong therapeutic bond change would appear as a result of client self-actualizing and growth tendencies (Ribeiro, 2009). In

turn, traditional gestalt therapists were more focused on the technical aspects of the working alliance, valuing the goals and tasks of therapy (Greenberg & Watson, 1998). Therefore, the working alliance in EFT – as an integration of the two perspectives – combines and privileges simultaneously the *relationship conditions* (bond) and the technical aspects or *working conditions of therapy* (goals and tasks) to benefit the most from a collaboration between clients and therapists during the process (Bordin, 1979; Ribeiro, 2009; Watson & Greenberg, 1998). This multifaceted and integrated view of the EFT alliance is in line with more current views arguing that the necessary and sufficient conditions of change are not so sufficient after all (Elliott, et al., 2004; Greenberg, 2002; Goldfried, 2007; Watson, 2007; Watson & Greenberg, 1998).

In addition, Watson and Greenberg (1998) affirm that, since the beginning of treatment, EFT therapists must create a safe relational environment that promotes client trust and the co-construction of treatment goals. Thus, at an initial stage of therapy, the focus is on establishing a therapeutic bond, facilitating the clients' capacity for turning inward to the exploration of emotional experience and entering the clients' world. Then, in the first sessions (usually until the fifth), therapist and client should collaboratively establish a therapeutic focus that will lead way to the more active therapeutic tasks (e.g. enactment tasks such as empty-chair exercises). The subsequent progression through emotional work implies that the EFT therapist has to constantly move in a continuum between *following* (client-centered stance) and *leading* (process guidance) the client, shifting several times between one and the other in the progression of a session (Pos & Greenberg, 2007). During task development, therapists must be especially attuned to clients in order to simultaneously *follow* and *lead* them through the experiential process, balancing between directiveness and responsiveness (Watson & Greenberg, 1998). As Greenberg assumes: "Although difficult, it is possible to enter into the highly subjective domain of unformulated personal experience, a place beyond reason and often beyond words, and have a positive influence." (2004, p. 6)

EFT tasks for depression

Depression is a complex clinical disorder affecting a large number of people, the majority of which are women (WHO, 2008). Previous research on EFT has provided significant evidence for the importance of emotion-focused work on depression: three clinical trials of 16 to 20 session-treatments compared the efficacy

of EFT in comparison with client-centered therapy (York I depression study – Greenberg & Watson, 1998 and York II depression study – Goldman, Greenberg & Angus, 2006) and cognitive-behavioral therapy (Watson, et al., 2003). Results from the combination of the York I and II samples showed that the EFT clients exhibited statistically significant differences in the level of depressive symptoms at 18-months follow-up after therapy when compared to client-centered sample, being also less likely to relapse (Ellison, et al., 2009). In comparison to cognitive-behavioral sample, EFT clients exhibited the same level of improvement at treatment termination, although there were some differences at the interpersonal level (EFT clients were significantly more self-assertive and less overly accommodating or compliant to others – Watson, et al., 2003).

These studies applied a manualized version of EFT (Greenberg, Rice & Elliott, 1993) to mild and moderately depressed clients that met criteria for major depressive disorder (according to the DSM – APA, 1980, 1994). Although all depressed clients present unique problematic issues, they usually share some common process-experiential difficulties, such as: (a) an emotional withdrawal and a sense of weakness, discouragement and disempowerment, (b) avoided or interrupted emotional experiencing, accompanied by fear or shame of core emotions and painful memories, and (c) rejection or disowning of significant parts of themselves, frequently with heightened self-criticism, shame, fear of abandonment and rejection by others or a deep sense of inadequacy (Greenberg & Watson, 2006).

The resolution of these issues is *marker-guided*, which means that a specific marker calls for a particular task (or operation), invited or introduced by the therapist. There are five central tasks in EFT for depression (see summary in table 1), even though others can also be used if necessary (Elliott, et al., 2004). A *problematic reaction point* is a marker based on client's puzzlement and confusion regarding one's own emotional reaction and calls for a *systematic evocative unfolding task.* This involves the recollection of the problematic situation in order to search for the connections between external events and internal reactions, allowing to clarify the meaning of the situation. An *unclear felt sense* refers to moments of a vague and obscure internal feeling or a sense of being blocked and calls for *focusing* (Gendlin, 1996). In this task, clients are invited to explore and expand awareness of their own internal reactions and to articulate in words the bodily-felt sense, labeling their emotions (i.e. symbolizing). A marker of *self-critical split* refers to a conflict between

two opposing parts of the self and calls for *two-chair dialogue*. This task is based on the separation of two voices (a critical voice and an experiencing voice), placed in each one of the chairs and invited to dialogue. It aims to foster the softening of the inner critical part and an integration of voices. Another kind of self-split involves *self-interruption* in which one part of the self (i.e. dominant) prevents the other (i.e. experiencing) to fully access and express one's experience. This calls for *two-chair enactment* in which the dominant part is invited to perform and verbalize the self-interruption so that the experiencing self gains awareness of this process and the blocked experience. Another marker is *unfinished business toward a significant other* and concerns poignant and lingering, unresolved feelings of the client whenever they activate an internal view of interpersonal past events. This calls for *empty-chair work* which involves placing the absent other in a chair and expressing the unexpressed, painful negative feelings in order to explore and make sense of these emotional reactions. Finally, the *vulnerability* marker, which is based on the expression of deep feelings of shame, inadequacy and powerlessness, calls for *an empathic affirmation* of the therapist. This is carried out with the aim of validating the client's experience, communicating acceptance and prizing in order to strengthen the self.

Table 1: An overview of central therapeutic tasks in EFT for depression

(Greenberg, Rice & Elliott, 1993, p. 138)

MARKER	OPERATION	END STATE
Problematic reaction point (Self-Understanding Problem)	Systematic Evocative Unfolding	New view of self in-the-world-functioning
Absent or Unclear Felt Sense	Experiential Focusing	Symbolization of Felt Sense; Productive Experiential Processing
Self-Evaluative Split (Self-Criticism, Tornness)	Two-chair dialogue	Self-acceptance, Integration
Self-Interruption Split (Blocked Feelings, Resignation)	Two-chair Enactment	Self-Expression, Empowerment
Unfinished Business (Lingering bad feeling Re: specific other)	Empty-chair Work	Forgive Other or hold other accountable, Affirm Self/Separate
Vulnerability (Painful emotion related to self)	Empathic Affirmation	Self-Affirmation (feels understood, hopeful and stronger)

NARRATIVE CHANGE IN PSYCHOTHERAPY[1]

Over the last decades, several authors have been acknowledging the centrality of *telling stories* in human lives (e.g., Angus & McLeod, 2004; Bruner, 1986; Hermans & Hermans-Jansen, 1995; McAdams, 1993; White & Epston, 1990). Self-narratives are products of the human effort to create meaning from our experience in the world and to have our perspectives validated by others, to whom we are dialogically intertwined (M. Gonçalves, Matos & Santos, 2009). The construction of meaning through self-narratives involves a process of interpretation, selection and synthesis of life experiences, where complex elements of episodic memory, personal and social expectations, emotional and interpersonal experiences are selected and diachronically integrated into a personal account of ourselves in the form of a story – a *self-narrative* (Adler, Skalina & McAdams, 2008; Boritz et al., 2008, 2011; McAdams, 1993). These self-narratives are not only a product but also a process, since they are performed to others in the specific interactional act of telling them. The segments of our past experience that are integrated in our personal stories become shaped by our prior and present more salient and more familiar experiences, both with social others and with ourselves. Additionally, the stories we tell are also constrained by the interlocutor and the context (for example, our self-narratives may vary according to the social role we are assigned in a given context).

Given the multivocal nature of these sources of narrative production (see Hermans, 1996), self-narratives involve processes of dialogical negotiation, disagreement and conciliation between self and other (this *other* can be specific social others, broader cultural messages and prescriptions, or even other parts of oneself). Therefore, the process of narrating a story pictures the self – as narrator – in dimensions that go beyond the narrated content. Self-narratives present the possibility of simultaneously revealing our authorship – by the way we view ourselves – and disclosing our position in the world – by the way we present ourselves to others (Wortham, 2001). As Hermans (1996) claims, this means that the self is simultaneously embedded in the content of the story and in the act of telling it to another person. According to some authors (Hermans, 1996; Sarbin, 1986), this dual

[1] Segments of this section appear in: Gonçalves, M. M., Cunha, C., Ribeiro, A. P., Mendes, I., Santos, S., Matos, M. & Salgado, J. (in press). Innovative moments in psychotherapy: dialogical processes in developing narratives. In M. Märtsin, B. Wagoner, L. Whittaker, E. M. Aveling, & I. Kadianaki (Eds.), *Dialogical science: The self in communication, culture and society*. New York: Nova Science Publishers.

feature of agency and positioning of the self – both as an author/narrator and as a social actor – is critically embedded in the unfolding narrative process, and it is through this process that the self can be transformed, for instance, in the psychotherapy context.

At this point, we would like to present an overview of the research programme that is being developed in our research centre addressing narrative change processes in psychotherapy, as it provided the context where the present PhD thesis was developed. Our departing point is the narrative metaphor of psychotherapy (Angus & McLeod, 2004; Bruner, 2004; Hermans & Hermans-Jansen, 1995; White & Epston, 1990) and the emphasis on the narrative construction and re-construction of the self (Bruner, 1986; McAdams, 1993; Sarbin, 1986), which assumes that clients transform themselves through the stories they tell – to themselves and to others. We also proceed from the idea that self-narratives entail particular dialogical processes (Hermans, & Hermans-Jansen, 1995; Hermans, & Kempen, 1993) that can become visible or enhanced in the psychotherapeutic setting. Furthermore, by adopting this dialogical and narrative standpoint, therapists and clients can use this inner multiplicity as an opportunity for change and the renewal of identity. While this general metaphor of *clients as storytellers* has framed our work in psychotherapy research, the re-authoring model of White and Epston (1990; see also White, 2007) and the dialogical perspective of Hermans and collaborators (Hermans, 1996; Hermans & Hermans-Jansen, 1995; Hermans & Kempen, 1993; Hermans & Dimaggio, 2004) have been shaping our conceptual lenses in the study of change in therapy. We will now present the main research findings deriving from our group and discuss the dialogical conceptualization that shapes the way we have been interpreting them.

The Innovative Moments perspective: Overview and findings

According to the re-authoring model of White and Epston (1990), clients frequently seek therapeutic help when the self has lost its ability to flexibly interpret the world, becoming trapped within redundant forms of meaning-making that are no longer capable of incorporating the diversity and multiplicity of lived experience. Hence, clients become entrapped in *problem-saturated stories* (White, 2007; White & Epston, 1990) or *same-old stories* (Angus & Greenberg, 2011).

Neimeyer, Herrero and Botella (2006) distinguish between three types of problematic narratives: (a) disorganized narratives, (b) dominant narratives and (c) dissociative narratives. *Disorganized narratives* appear when the person is not capable of articulating a coherent account of his or her identity after experiencing intensely painful events (like loss). These deeply shattering experiences disrupt the former sense of selfhood due to invalidating core emotional themes and values and cannot be articulated in a coherent account of personal identity (Botella, Herrero, Pacheco & Corbella, 2004; Dimaggio, et al., 2003). *Dominant narratives* are all-encompassing stories that usually favour one perspective over multiple others and dismiss discrepant experiences that contradict the main, dominant theme (M. Gonçalves & Guifoyle, 2006; M. Gonçalves, Matos & Santos, 2009; O. Gonçalves & Machado, 1999; Hermans & Hermans-Jansen, 1995; Salvatore, et al., 2010; Santos & Gonçalves, 2009; White & Epston, 1990; White, 2007). *Dissociative narratives* concern the exclusion of significant traumatic memories from awareness and narration (such as trauma-related experiences), thus evidencing difficulties at the level of autobiographical memory recall (Boritz, et al., 2008, 2011; Dimaggio, et al., 2003; Neimeyer, Herrero & Botella, 2006). All these problematic narratives tend be associated to psychopathology and maladjustment (White, 2007; White & Epston, 1990).

In this perspective, therapy can be an opportunity for: (a) gaining a new sense of personal coherence and structure while repairing disorganized narratives; (b) becoming aware of the constraining power of dominant narratives, overcoming them by increasing flexibility and multiplicity; and (c) developing the integration of previously excluded experiences when dealing with dissociative narratives (Neimeyer, Herrero & Botella, 2006). These changes happen progressively as a consequence of exceptional events that fall outside the rules prescribed by these problematic narratives. These exceptions appear every time clients narrate stories or talk about acting, feeling or thinking in new ways and operate in ways that contradict the problem's rules. These moments have been termed *unique outcomes* by White and Epston (1990), but we prefer referring to them as *innovative moments* (Gonçalves, Matos & Santos, 2009). By bringing the client's awareness to these exceptional moments opposing the problem, an attentive therapist can introduce novelty in meaning making and, thus, create opportunities for the emergence of new self-narratives (White, 2007).

When we began our research project, we directly took the notion of *unique outcomes* to analyse data but our terminology evolved along with our findings (M. Gonçalves, Matos & Santos, 2009). We now prefer the notion of *innovative moments* (IMs), which has become the central concept of our research programme. Two reasons support this preference: first, *unique* might convey the misleading idea – for readers unfamiliar with the re-authoring model – of rare experiences appearing outside the problematic rule. However, these exceptions occur quite frequently in therapy, even in unsuccessful cases. Second, the term *outcomes* stresses results or outputs and, as we shall argue, these innovations reflect a developmental process building up towards a given therapy outcome at the termination of treatment (that involves not only the remission of symptom but also the transformation of self-narratives). It is because we are more interested in the developing nature of narrative transformations in therapy that we favour the notion of IMs over unique outcomes.

In our initial studies, which began with a sample of narrative therapy with women who were victims of domestic violence (Matos, Santos, M. Gonçalves & Martins, 2009), we inductively identified five types of IMs: *action*, *reflection*, *protest*, *reconceptualization* and *performing change* (M. Gonçalves, Matos & Santos, 2009).

Action IMs are events when the person acted in a way that is contrary to the problematic self-narrative.

Clinical vignette 1 (Problematic narrative: agoraphobia)[2]

Therapist: Was it difficult for you to take this step (not accepting the rules of "fear" and going out)?

Client: Yes, it was a huge step. For the last several months I barely went out. Even coming to therapy was a major challenge. I felt really powerless going out. I have to prepare myself really well to be able to do this.

Reflection IMs refer to new understandings or thoughts that undermine the dominance of the problematic self-narrative, sometimes involving a cognitive challenge to the problem or cultural norms and practices that sustain it. In this sense,

[2] The clinical vignettes illustrating the types of IMs are drawn from the Innovative Moments Coding System: Gonçalves, M. M., Matos, M., & Santos, A. (2008). Innovative Moments Coding System – Version 7.2. *Unpublished manuscript*. University of Minho, Braga.

reflection IMs frequently assume the form of new perspectives or insights of the self, somehow contradicting the problematic self-narrative.

Clinical vignette 2 (Problematic self-narrative: depression)

Client: I'm starting to wonder about what my life will be like if I keep feeding my depression.

Therapist: It's becoming clear that depression has a hidden agenda for your life?

Client: Yes, sure.

Therapist: What is it that depression wants from you?

Client: It wants to rule my whole life and in the end it wants to steal my life from me.

Protest IMs involve moments of critique, confrontation or antagonism towards the problem (directed at others or at oneself), its specifications and implications or people that support it. Opposition of this sort can either take the form of actions (achieved or planned), thoughts or emotions; however, it necessarily implies an active form of resistance, repositioning the client in a more proactive confrontation to the problem (which does not happen in the previous action and reflection IMs). Thus, in this type of IMs we can always distinguish two positions in the self (implicit or explicit): one that supports the problematic self-narrative and other that challenges it. When protest occurs, the second position acquires more power than the first.

Clinical vignette 3 (Problematic self-narrative: feeling rejected and judged by her parents)

Client: I talked about it just to demonstrate what I've been doing until now, fighting for it.

Therapist: Fighting against the idea that you should do what your parents thought was good for you?

Client: I was trying to change myself all the time, to please them. But now I'm getting tired, I am realising that it doesn't make any sense to make this effort.

Therapist: That effort keeps you in a position of changing yourself all the time, the way you feel and think.

Client: Yes, sure. And I'm really tired of that. I can't stand it anymore! After all, parents are supposed to love their children and not judge them all the time.

Reconceptualization IMs are closer to stories due to their time-sequencing nature. In these types of narratives there is a personal recognition of a contrast between the past and the present in terms of change, and also the personal ability to describe the processes that lead to that transformation. It is because the person is capable of describing the processes underneath the achieved changes – through a meta-reflective level – that these IMs are more complex than action, reflection and protest. Not only clients are capable of noticing something new, but also they are capable of recognizing themselves as different when compared with the past, due to a transformation process that happened in between. Thus, reconceptualization IMs always involve two dimensions: a) a description of the shift between two positions (past and present) and b) the transformation process that underlies this shift.

Clinical vignette 4 (Problematic self-narrative: domestic violence and its effects)

Client: I think I started enjoying myself again. I had a time… I think I've stopped in time. I've always been a person that liked myself. There was a time… maybe because of my attitude, because of all that was happening, I think there was a time that I was not respecting myself… despite the effort to show that I wasn't feeling… so well with myself… I couldn't feel that joy of living that I recovered now… and now I keep thinking "you have to move on and get your life back".

Therapist: This position of "you have to move on" has been decisive?

Client: That was important. I felt so weak in the beginning! I hated feeling like that…. Today I think "I'm not weak". In fact, maybe I am very strong, because of all that happened to me, I can still see the good side of people and I don't think I'm being naïve… Now, when I look at myself, I think "no, you can really make a difference, and you have value as a

person". For a while I couldn't have this dialogue with myself, I couldn't say "you can do it" nor even think "I am good at this or that".

The final category is *performing change IMs*. These refer to new aims, projects, activities or experiences – anticipated or acted – that become possible because of the acquired changes. Clients may apply new abilities and resources to daily life or retrieve old plans or intentions postponed due to the dominance of the problem.

Clinical vignette 5 (Problematic self-narrative: domestic violence and its effects)

Therapist: You seem to have so many projects for the future now!

Client: Yes, you're right. I want to do all the things that were impossible for me to do while I was dominated by fear. I want to work again and to have the time to enjoy my life with my children. I want to have friends again. The loss of all the friendships of the past is something that still hurts me really deeply. I want to have friends again, to have people to talk to, to share experiences and to feel the complicity of others in my life again.

According to Bruner (1986), narratives always imply two landscapes: on the one hand, there is the *landscape of action* that refers to who the actors are, what actions are taking place, and what setting or scenario is framing the development of the plot. On the other hand, there is the *landscape of consciousness* that refers to what the actors know, feel, think, value or plan. If we take these dimensions, we could clearly say that action IMs belong to the landscape of action while reflection IMs belong to the landscape of consciousness, each being "pure" representatives of that particular dimension. Protest IMs, in turn, can occur in one landscape or the other, or even have elements from both; likewise, performing change can be situated at both landscapes, since they can refer to new feelings or thoughts (landscape of consciousness) and also actions and plans (landscape of action) triggered by change.

Reconceptualization IMs, as they involve a meta-reflective level, usually combine elements from both landscapes, integrating them.

1. The Innovative Moments Coding System. The five types of IMs presented above were systematised in the *Innovative Moments Coding System* (IMCS; M. Gonçalves, Ribeiro, et al., 2011; M. Gonçalves, Ribeiro, et al., in press), a qualitative method applicable to various research projects, from single cases to samples from different therapeutic models and even interviews about problems outside psychotherapy. The application of the IMCS requires at least two trained judges. Their training requires the familiarisation with the relevant theoretical notions and coding procedures, through several training exercises. After training, the two judges engage independently in an initial reading/listening/visualisation of the materials (sessions or interviews) in order to be familiarized with the problems under analysis and their development. Next, the judges meet in order to discuss and agree in terms of what the problematic self-narrative is and the different dimensions that it involves (personal, interpersonal, professional, etc). A list of problems is, then, consensually elaborated in close approximation to the client's self-narrative (in terms of words, expressions, metaphors). The following independent identification of IMs departs from this first step. IMs are always identified in their relation to the previously identified problematic self-narrative and it takes into consideration the specificity of the problem: for example, the act of "*walking away from the situation*" can be regarded as an IM in relation to a problem of domestic violence or, alternatively, in a different case it can be part of the avoidant behaviour that sustains a panic disorder.

Each session is analysed independently by each judge (for further details, see M. Gonçalves, Ribeiro, et al., in press). First, they identify IMs, defining their onset and offset in the session. Second, they categorize IMs in terms of the five types (action, reflection, protest, reconceptualization and performing change). Then, the *salience* of IMs is computed as the proportion of time (in seconds or in number of words) occupied by each IM. Several indexes of IMs' salience can be computed: salience of each type of IM in each session or the overall salience of IMs (as the mean score of IMs' salience) for a given session or the entire case. To assess reliability, researchers use (a) the interjudge percentage of agreement of overall salience and (b) Cohen's κ for salience and IMs' codings, respectively (Hill & Lambert, 2004).

2. Major findings with the IMCS. Up until now, several studies have been carried out with different therapeutic modalities and client samples in order to test the applicability of the IMCS to other therapies beside the narrative (Matos et al., 2009). Additionally, several case studies from different therapeutic orientations have also been studied at a more microanalytic level (Alves et al., 2011; M. Gonçalves, Mendes, Ribeiro, Angus, & Greenberg, 2010; Ribeiro, M. Gonçalves & Ribeiro, 2009; Santos, M. Gonçalves, Matos, & Salvatore, 2009).

2.1. Findings from therapy samples. Besides narrative therapy (Matos et al., 2009), the IMCS has been applied to a sample of EFT with depressed clients (Mendes, et al., 2010), a sample of client-centered therapy also with depressed clients (M. Gonçalves, Mendes, Cruz, Ribeiro, Sousa, Angus & Greenberg, 2011). These studies usually contrast good (GO) and poor outcome (PO) groups in psychotherapy (distinguished through the pre- and post-treatment assessment of symptoms).

Overall, these studies have presented consistent findings regarding the salience of IMs and their pattern of evolution. A first distinctive feature is that the overall salience of IMs is significantly higher in GO when compared to PO cases. More specifically, GO cases are typically characterized by a progressive tendency in the diversity of IMs and in their salience from session to session. In the beginning of therapy, action, reflection and protest IMs start emerging and their salience increases during the sessions. Then, in the middle of therapy, reconceptualization IMs appear and their salience continues increasing until the end, becoming the more important type. Performing change IMs tend to appear after reconceptualization. In turn, PO cases are typically characterized by a lower diversity and salience of IMs, with action, reflection and protest being the main IMs, most of the time without a clear trend to increase from the beginning until the end of treatment (thus remaining stable). Reconceptualization and performing change IMs typically do not appear or have a very low salience in PO cases.

An interesting commonality between the groups is the presence of IMs from the first session until the end, regardless of the therapeutic outcome. This suggests that, even when the problematic narrative dominates in the beginning and keeps dominating until the end, there are always novelties appearing and opportunities for new narratives to be developed, even if they are ignored, trivialized or dismissed after their emergence.

2.2. Findings from EFT. Specifically in EFT, Mendes et al. (2010) also found that the overall salience of IMs was lower in PO, when compared with GO. The PO group exhibited low action, almost no reconceptualization and an absence of performing change IMs; only reflection and protest IMs appeared throughout therapy. In contrast, the GO group had higher IMs' salience, with all the types of IMs present. According to their analysis focused on the contrast between groups, reconceptualization and performing change were the only IMs that distinguished the outcome groups, with their salience exhibiting an increasing trend from the middle of therapy until the end. Therefore, and congruently with the other samples, these results provided evidence that indicate that reconceptualization and performing change IMs, also play a role on narrative change in EFT, even though EFT therapists are not explicitly focused on the promotion of these narrative novelties.

However, some specificities were also noted in the study by Mendes et al. (2010), particularly in the comparison between EFT and the narrative therapy sample: (a) the low salience of action IMs in both outcome groups, and (b) the low salience of performing change in the GO when compared to the GO of narrative therapy (which was almost the double: EFT – 1.72%; narrative therapy – 3.34%). This finding is actually congruent with the EFT theory which suggests that the focal point of change is not the promotion of innovative actions but the differentiation and transformation of emotions and respective symbolization (Mendes et al., 2010).

2.3. Findings from narrative change outside the therapy setting. The results from psychotherapy were also replicated in studies of daily life changes (i.e., changes related to personal problems, transitions and processes of adaptation to life events that occur outside the therapeutic context). Cruz and M. Gonçalves (in press) conducted an exploratory study based on interviews with a non-clinical population that asked participants to identify three types of difficulties in their lives: past (and solved) difficulties, current difficulties (in the moment of the interview) and persistent difficulties (present for more than 6 months). In this study, only reconceptualization IMs distinguished solved from current difficulties. A similar study by Meira (2009; see also Meira, M. Gonçalves, Salgado & Cunha, 2009) on non-therapeutic change with a longitudinal design replicated the same findings about reconceptualization, since only this IM distinguished between solved and non-solved difficulties.

The consistency of these findings within and outside the therapeutic context suggests that reconceptualization is a key factor for sustaining narrative changes and the construction of new self-narratives. This lead M. Gonçalves and colleagues (M. Gonçalves, Matos & Santos, 2009; M. Gonçalves, Ribeiro, et al., in press) to integrate the IM's findings in the elaboration a heuristic model of narrative change.

3. A model of narrative change in psychotherapy from the IMs' perspective.

According to the IMs' model, narrative change implies not only diversity of IMs but also specific interrelations between them. Due to the complexity of self-changes, it is unlikely that sustained changes could develop from a specific type of IM (M. Gonçalves et al., 2009). So, according to our findings, change starts with IMs' diversity, namely in the form of action and reflection IMs. These are more elementary forms of innovation that appear as early forms of opposing the problematic self-narrative. Nevertheless, these IMs are considered vital because, when recognized by the person and validated by others, they become the first signs that something new is taking place and that change is on its way. These novel actions, thoughts or intentions, either triggered by the therapist's questions or spontaneously recognised by the client, defy the dominant problematic themes that prescribe redundant behaviour. The way these innovations appear can be quite idiosyncratic to the person or situation: sometimes they appear through new actions that lead to new thoughts and intentions, other times through new insights about the problem's maintenance that feed new actions. We have also noticed that protest IMs can be present from the first session on, in some cases. This can be due to the fact that not all clients enter therapy at the same stage of change (see Prochaska, DiClemente & Norcross, 1992). Some seek therapy already engaged in an active state, while others are still very contemplative and ambivalent and may take more time reflecting and exploring the problem before they gather enough motivation to enter in more active stages (Prochaska et al., 1992; see also M. Gonçalves, Ribeiro, et al., 2011). We consider protest IMs an interesting type of innovation since they trigger a strong attitudinal movement against the problem and entail new positioning of the self in relation to the surrounding world.

Regardless of the starting point, the idea is that these three forms of IMs keep feeding each other and amplifying their occurrence. For example, as the person starts recognising that the avoidance of certain activities only maintains the problem of fear, she might decide and plan to start doing small things that defy the problem (reflection

IM) and actually starts re-experimenting in his or her daily life with previously abandoned activities (action IMs) while at the same time protesting frequently in therapy towards the problem's assumptions (protest IMs).

At a certain point in therapy (usually in the middle of the process) reconceptualization IMs start to appear. These IMs are very important to the consolidation of further narrative changes, given that PO therapy cases and non-solved personal problems usually do not exhibit them. Since reconceptualization IMs are grounded in two important features: a) the contrast between present and past and b) a meta-level narration of the processes that made this transformation possible, they seem to be a type of narrative which is more complex than the previous IMs. Not only is its structure closer to the structure of a story (given its sequencing of events and higher narrative coherence), but it also gives a meta-level view of the agent in a story about change. In this sense, it pictures the person (as an actor) in a given path towards self-transformation and, at the same time, frames the story in a new authorship perspective (as a narrator and author, the person positions him or herself as different). Furthermore, these IMs also foster other action, reflection and protest IMs, acting like an integrative story about the self that facilitates the creation of new projects and changed experiences in the future. Since the person – as a changed narrator – assumes a different authorship stance towards the self and the world, reconceptualization IMs give coherence to the several types of novelties, acting as a meaning bridge (Osatuke & Stiles, 2006) between the old and new versions of the self. Thus, reconceptualization has the power of integrating old patterns into new ones, synthesising new with the old (Santos & M. Gonçalves, 2009).

Finally, performing change IMs emerge and represent the expansion of the change process into the future, as new experiences, projects and intentions emerge due to the transformations achieved. The future projection of a story is vital for an expansion of new self-narratives: as several authors suggest (Crites, 1986; Omer & Alon, 1997), new stories need to have a future.

4. Ambivalence in the path to change: A model of narrative stability. A closer look comparing of the initial therapy phases of GO and PO cases reveals a few communalities between the groups, particularly in the initial phase of therapy M. (Gonçalves, Mendes, et al., 2011; Matos, et al., 2009; Mendes, et al., 2010): action, reflection and protest IMs are present (although in some PO cases the salience of

these IMs is lower than in GO cases from the very beginning). Clearer differences appear in the middle of therapy when – in the absence of reconceptualization – the potential power of action, reflection and protest IMs is not built upon and amplified to foster further changes. Therefore, the overall picture is: despite some innovations, the person returns to the same narrative, not being able to challenge its dominance. Thus, the crucial question is: What blocks the development of IMs in the PO cases?

All therapeutic models have some way of addressing stagnation when it appears during the therapeutic process; usually, it falls under the notion of *ambivalence* or the more traditional concept of *resistance* (Arkowitz, 2002; Engle & Arkowitz, 2006, 2008). Under the IMs' model, the exploration of the processes that facilitate the maintenance of the problematic self-narrative and prevent the emergence of reconceptualization, involves taking into account the potential that IMs have to challenge a client's usual way of understanding and experiencing oneself. IMs can be easily understood as episodes of self-discontinuity and, consequently, trigger uncertainty and disruptive affect (M. Gonçalves & Ribeiro, in press; Ribeiro & M. Gonçalves, 2010; Zittoun, 2007).

In this line of reasoning, the development of IMs into the consolidation of a new self-narrative depends on the way the person is able to deal with and sustain the emergence of uncertainty in the change process. In our view, the maintenance of the problematic self-narrative by ignoring or avoiding uncertainty through the return to the problematic self-narrative may be a useful way to look at ambivalence in psychotherapy and understand problematic self-stability (M. Gonçalves, Ribeiro, et al., 2011; Santos, M. Gonçalves & Matos, 2010). That is, psychotherapy stagnation may be the product of a cyclical relation between the problematic self-narrative and IMs, which blocks the development of further innovation and the emergence of a new self-narrative. The following example shows how, although the client elaborates an IM, this novelty is aborted by a return to the problematic self-narrative that restores self-continuity (i.e., reinstates the dominance of the problematic self-narrative):

Clinical vignette 6

Client: **Sometimes I feel able to face my fears... I feel this strength inside me** [Reflection IM], ***but then it suddenly disappears, as if my fears return and takeover!*** **[**Returning to the problematic self-narrative, securing self-continuity**]**

This is akin to what Valsiner (2002) described as *mutual in-feeding*: a dynamic balance between two contrasting voices in the dialogical self that feed each other in a perpetual movement back and forth (the notion of voices here refers to parts of the self that have some form of inner expression and can engage in dialogue with other parts of the self; e.g., voice A: "life is good" addressing voice B, which replies: "life is bad"). According to Valsiner (2002), the most interesting thing is that despite the small variability gained through the oscillation between voices over time, the relationship between them remains the same as it was in the beginning (i.e. opposition). This is a case of stability through a very dynamic process within the dialogical self (Hermans & Kempen, 1993). The process of mutual in-feeding has been addressed by other authors in different theoretical perspectives. For example, in personal construct theory, it is sometimes referred to as *slot rattling* (Kelly, 1955), a dance between two poles of the same construct. In the assimilation model of Stiles (1990, 2002), this is equivalent to the concept of *rapid-cross fire* between two divergent voices (Brinegar et al., 2006), a sub-stage of APES level 4.

A study recently conducted by M. Gonçalves, Ribeiro, et al. (2011) with the sample of narrative therapy found that the PO group had a significantly higher percentage of IMs followed by return-to-the-problem markers (i.e. linguistic markers appearing after IMs that represent its negation and suggest the process of mutual in-feeding; e.g. words like *but*, *however*). These occurred mainly after action, reflection and protest IMs. Furthermore, the return-to the problem markers were also rare after reconceptualization and performing change IMs, suggesting that these types of IMs are less caught within the process of mutual in-feeding.

One possible reason for this is the idea that reconceptualization IMs already dialectically integrate both opposites (past and present or, in other words, problematic voice and innovative one), making it difficult for an oscillation between them. Performing change IMs may also escape this process of mutual in-feeding because

they tend to emerge only after reconceptualization, being more characteristic of final phases of therapy. Moreover, according to the definition of performing change IM, they are the anticipation or planning of new experiences and projects. Since these projects and new experiences appear as a generalisation of the change process into other life domains and into the future, it is likely that they are not involved in a return to the problem.

INTRODUCING THE CURRENT STUDIES

These findings with the IMCS consistently assigned a key role to reconceptualization IMs. As we have seen, these narratives about *the self in a transformation process* were related to good outcome therapy in narrative therapy with victims of domestic violence (Matos et al., 2009), client-centered therapy for depression (Cruz, 2011; M. Gonçalves, Mendes, et al., 2011), constructivist grief therapy (Alves, et al., 2011), and – most importantly for the present dissertation – EFT for depression (Mendes et al., 2010, 2011). Besides portraying the self in a dynamic temporal movement, these IMs play a significant part in self-narrative change and have the ability to foster new forms of innovation such as performing change IMs, also related to good outcome therapy. As Matos and colleagues (2009, p. 9) stated:

> …re-conceptualization IMs allow the person to be not only an actor of his or her self-narrative but, more importantly, an author. (…) Re-conceptualization IMs are the most complex ones, given the involvement of a metaposition over change, creating a decentering from the client and an ability to see what is becoming different from the old plot and what new paths may occur in the new narrative. Thus, these IMs are very proactive and creative, denoting a clear preference that the person has for the new story.

Therefore, we followed the suggestion made by Mendes et al. (2010), who claimed that "the reasons why reconceptualization seems so vital in the change process need to be deeply analyzed with different methodological approaches" (p. 699) and set out to investigate this notion through a diversity of methodological proposals to study change processes (Elliott, 2010). Hence, the general goal of this dissertation was to explore theoretically and empirically the notion of reconceptualization, highlighting its functions in narrative change in EFT, and discover how therapists can explicitly promote it. We now briefly summarize the chapters of this dissertation.

Chapter I presents a study on the association between therapist interventions related with IMs in a sample of EFT for depression. Using the Helping Skills System (Hill, 2009) we analysed the initial, middle and final sessions of six EFT cases – 3 GO and 3 PO cases – drawn from the York I depression study (Greenberg & Watson, 1998), with the aim to investigate:

(a) How different skills evolve in EFT,

(b) Whether different skills precede IMs when compared with non-IMs, and

(c) Whether different skills precede different types of IMs.

Given the nature of EFT, our expectation was that therapist exploration and action skills would be more associated to IMs when compared with insight skills. Furthermore, we also intended to study which skills were used by therapists immediately before the emergence of action, reflection and protest IMs (related to both poor and good outcome therapy), or before the emergence of reconceptualization and performing change IMs (related only to good outcome).

Given the focused but limited scope of the first study, we proceeded to the development of a more in-depth, theory-building (Stiles, 2007), qualitative analysis of a case – the case of Sarah (Honos-Webb, Stiles & Greenberg, 2003), presented in chapter II. Realizing that reconceptualization IMs involve a rupture in the self (Zittoun, 2006), since the self in the present (changed) is no longer the same as it was in the past (i.e. trapped within a problematic narrative), we aimed to explore the transition process between Sarah's contrasting self-narratives (old and new). More specifically, we had two research questions in mind:

(a) How and why reconceptualization IMs reflect the developing process of self-narratives during therapy evolution? This means understanding both the process of development and the function of reconceptualization IMs.

(b) How does the therapist participate in the process of facilitating these changes and restoring self-continuity in the client? This implies focusing on the content of the therapeutic interventions (given that this was not accessible through the quantitative results of the first study), attempting to understand how these facilitated client changes at the level of the narrative reorganization of the self.

Departing from some theoretical ideas drawn from the case of Sarah, chapter III explores the different forms of ambivalence that emerge in the first

reconceptualization IMs of three good outcome cases of EFT: Sarah, Jan and Lisa (Honos-Webb, et al., 1998, 1999, 2003). The goal here was to discuss and illustrate how therapy can elicit feelings of fear, anxiety and ambivalence towards change – particularly changes occurring in the self, which evoke a sense of unfamiliarity with oneself, even though these may be desired by clients from the very beginning of therapy. These forms of ambivalence are integrated, according to the innovative moments' perspective, in a mutual in-feeding process between problematic self-narrative and innovative moments (M. Gonçalves, Ribeiro, et al., 2011; Valsiner, 2002). Furthermore, this chapter considers the important therapeutic strategy of developing a metaposition in the self that allows overcoming and transforming ambivalence.

Globally, the second and third studies showed that reconceptualization IMs are a heterogeneous entity that changes throughout the therapeutic process. Thus, the fourth study presented in chapter IV looks at how the assimilation model of Stiles (1999, 2001) can be used to examine the notion of reconceptualization and the diversity of reconceptualization IMs in therapy.

The assimilation model (Stiles, 1999, 2001; Stiles, Elliott, Llewelyn, Firth-Cozens, Margison, Shapiro & Hardy, 1990) states that successful therapy reflects a gradual, developing process of acknowledging and understanding problematic experiences, assimilating them in the overall community of the self. Intensive case-studies conducted under this framework led to the elaboration of the Assimilation of Problematic Experiences Sequence (APES – Stiles, 1999; 2001) that describes eight qualitatively distinct stages of assimilation of problematic experiences: (0) warded off/dissociated; (1) unwanted thoughts/active avoidance; (2) vague awareness/emergence; (3) problem statement/clarification; (4) understanding/insight; (5) application/working through; (6) resourcefulness/problem solution; (7) integration/mastery.

This change model was used here to study the differentiation and productivity of reconceptualization IMs, through the analysis of the APES levels attributed to all these narratives appearing in the previous sample of EFT. This time, we had the following three research questions:

(a) How are reconceptualization IMs distributed along the APES levels in a sample of EFT for depression (3 good and 3 poor outcome cases)?

(b) Are there differences between groups in the APES levels of reconceptualization IMs of good and poor outcome cases? and,

(c) Are there differences in the APES levels of reconceptualization IMs appearing in distinct EFT phases (initial, middle and final)?

The fifth and last study is found in chapter V, which presents a preliminary task-analysis of narrative reorganization in EFT for depression. This task-analytic study explored how client-therapist dyads in EFT departed from the exploration of a problem (beginning point) to arrive at a changed view of the self, organized in a new narrative (end point). The narrative reorganization task was located within sessions through the repeated emergence of reconceptualization IMs or, alternatively, the emergence of reconceptualization IMs articulated with performing change IMs. First, a rational (abstract) model of the task was built by researchers drawing upon their previous clinical and research experience. Then, this model was contrasted with several real in-session episodes (therapeutic excerpts) and finally revised and refined until model saturation (i.e. new episodes do not change the model). Chapter V presents the rational-empirical model of the narrative reorganization of the self and discusses the central aspects of therapist activity in the facilitation of this process.

Before concluding this introduction, we would like to acknowledge some redundancy throughout the chapters given that each one characterizes the IMCS, its findings, the model of narrative change developed in this perspective and, particularly, the notion of reconceptualization. This is due to the format of the dissertation, since each chapter is an independent paper already submitted or prepared for future submission to publication.

CHAPTER I

THERAPIST INTERVENTIONS AND CLIENT INNOVATIVE MOMENTS IN EMOTION-FOCUSED THERAPY FOR DEPRESSION

CHAPTER I

THERAPIST INTERVENTIONS AND CLIENT INNOVATIVE MOMENTS IN EMOTION-FOCUSED THERAPY FOR DEPRESSION[3]

1. ABSTRACT

We explored the association between therapist skills (exploration, insight and action) and innovative moments in two initial, two middle and two final sessions of 3 good and 3 poor outcome cases of emotion-focused therapy (EFT) for depression. Exploration skills were used more frequently than insight and action skills in both good and poor outcome cases. Insight skills occurred more often in poor than good outcome cases, but as all the other skills they were more often associated with innovative moments in good outcome cases. In good outcome cases the probability of skills preceding innovative moments increased from the initial to middle phase and stayed the same in the final phase. In poor outcome cases, the probability of skills preceding innovative moments was highest in the middle phase.

2. INTRODUCTION TO STUDY 1

2.1. Innovative moments and narrative change

According to a narrative framework of therapy (e.g., White & Epston, 1990; White, 2007), clients seek help when they feel overwhelmed by their life difficulties and have lost the ability to flexibly create meanings outside the scope of problematic self-narratives. These problematic self-narratives can be disorganized and nonspecific, lacking a coherent sense of personal agency (Boritz, Angus, Monette & Hollis-Walker, 2008; Botella, Herrero, Pacheco & Corbella, 2004), or can highlight hurtful experiences, evidencing a bias towards negative events on autobiographical recall (O. Gonçalves & Machado, 1999).

Several authors have emphasized the importance of encouraging client elaboration of new stories or narrative novelties in psychotherapy as a way of promoting therapeutic change (Angus & McLeod, 2004; Dimaggio, Salvatore, Azzara

[3] This study has been submitted for publication to the journal *Psychotherapy* with the following authors: Carla Cunha, Miguel M. Gonçalves, Clara E. Hill, Inês Sousa, Inês Mendes, António P. Ribeiro, Lynne Angus, and Leslie S. Greenberg.

& Catania, 2003; M. Gonçalves, Matos & Santos, 2009; M. Gonçalves & Stiles, 2011; Levitt, Korman & Angus, 2000; White & Epston, 1990). These novelties, or innovative moments (hereby IMs), refer to new actions, thoughts, and experiences that appear as changes are achieved.

Five types of IMs have been observed and reliably identified using the Innovative Moments Coding System (IMCS - M. Gonçalves, Matos, & Santos, 2009; M. Gonçalves, Ribeiro, Mendes, Matos, & Santos, 2011). In action IMs, the client describes behaviors that challenge the problematic self-narrative. In reflection IMs, new understandings or thoughts emerge that are not congruent with the problematic pattern. In protest IMs, the client actively refutes the problem, the assumptions behind it, or people that support the problematic way of functioning. In reconceptualization IMs, the client provides a contrast between a previous problematic self-narrative and an adaptive emergent one and states an understanding of the processes that allowed this transformation. In performing change IMs, the client anticipates or plans new experiences, projects, or activities based on the changes made.

Previous studies have shown that IMs occur more often in good than poor outcome cases (Matos, Santos, M. Gonçalves, & Martins, 2009; Mendes, Ribeiro, Angus, Greenberg, Sousa, & M. Gonçalves, 2010; M. Gonçalves, Mendes, Cruz, Ribeiro, Sousa, Angus, & Greenberg, 2011), providing evidence for the validity of IMs. Furthermore, although action, reflection, and protest IMs occurred in both good and poor outcome cases, reconceptualization and performing change occurred more often in good than poor outcome cases (Matos et al., 2009; Mendes et al., 2010), suggesting that reconceptualization and performing change IMs are particularly necessary for good outcome.

Based on these findings, M. Gonçalves et al. (2009) developed a model that describes the sequential nature of IMs in psychotherapy. They suggested that action, reflection and protest are the first types of IMs to emerge and function to challenge the problematic self-narrative. These three types of IMs occur interactively, such that each fuels the others. Protest IMs typically emerge after reflection and action, although sometimes protest IMs occur first along with action and reflection IMs.

In good outcome cases, reconceptualization IMs begin to appear in the middle phase of therapy and continue as the dominant type until the end. Reflection, action and protest IMs still occur in the middle and end of good outcome therapy and reinforce the reconceptualization IMs. After some development of reconceptualization

IMs, performing change IMs emerge and extend the self-narrative, indicating that the client is developing new ways of making sense of self and others.

Although it makes sense that therapists help to facilitate IMs, we have no empirical evidence for what therapist behaviors are associated with IMs, and if different therapeutic skills are associated with different types of IMs. Knowing more about whether and which specific therapist skill are associated with IMs would have implications for training therapists to facilitate IMs, so research is clearly needed on this topic.

2.2. Therapist skills

Some of the earliest process research in the 1940s (e.g., Snyder, 1945) involved the categorization of therapist skills (also known as verbal actions or verbal response modes). This line of research has remained popular, with more than 30 different category systems (e.g., Hill, 1978; Stiles, 1979) having been developed. It certainly makes sense to capture what therapists overtly do during sessions as a way of characterizing the therapist effect in psychotherapy. Empirical research has shown, for instance, that therapists from different theoretical orientations used skills differently (e.g. Hill, Thames & Rardin, 1979; Stiles, Shapiro & Firth-Cozens, 1989), that specific skills were associated with the establishment of an empathic therapeutic alliance (Barkham & Shapiro, 1986; Fitzpatrick, Stalikas, & Iwakabe, 2001), and that skills can be taught (see review in Hill & Lent, 2006).

A special issue of *Psychotherapy* in 2005 was dedicated to the interplay of therapist techniques and the therapeutic relationship, providing a more complex conceptualization of the role of therapist skills in the psychotherapy process (Gelso, 2005). The take-home message of this special issue was that therapist techniques play a role in the therapeutic relationship and facilitate the outcomes within each therapeutic dyad (e.g., Goldfried & Davila, 2005; Hill, 2005). Furthermore, Gelso (2005) also pointed out the need to promote more research on the interplay of therapeutic techniques, the relationship and change processes within the framework of humanistic/experiential perspectives, such as Emotion Focused Therapy (EFT). Given the proposition that therapist interventions interact with client involvement, the therapeutic relationship, and the phase of therapy, Hill (2005) recommended that we must account for each of these dimensions in any study. Hence, in the present study, we set out to investigate the connection between therapist skills and client IMs within

the initial, middle, and final phases of EFT for depression using a microanalytic sequential process design (Elliott, 1985; 2010).

2.3. Purpose of the present study

Our overall purpose was to investigate the association between therapist skills and IMs in initial, middle, and final sessions of good and poor outcome cases of EFT for depression. For this, we investigate (a) how different skills evolve in EFT, (b) whether different skills precede IMs, and finally (c) whether different skills precede different types of IMs. We used the IM codings from the Mendes et al. (2010) study of EFT for depression, and extended the results of that study by examining the therapist skills associated with the IMs. Our rationale for choosing EFT cases for this study is that EFT has been shown to have a high proportion of IMs (M. Gonçalves et al., 2011; Matos et al., 2009; Mendes et al., 2010). Because the goals of EFT are to facilitate the client's experiencing, exploration of organismic needs, and transformation of maladaptive emotions into adaptive ones (Greenberg, 2006; Greenberg, Rice, & Elliott, 1993; Pos & Greenberg, 2007), it makes sense that IMs would occur frequently in EFT. Thus, a sample of EFT cases is a good place to look for correlates of IMs.

3. METHOD

3.1. Participants

The cases used for this study were from the York I depression study (Greenberg & Watson, 1998). Each client in that study was randomly assigned to EFT or client centered therapy (CCT) and attended 15 to 20 weekly sessions. In the present study, we used the 3 good outcome and 3 poor outcome cases from the EFT sample that were identified by Mendes et al. (2010). The average Beck Depression Inventory (a 21-item self-report inventory of depressive symptoms; Beck, Steer, & Garbin, 1988; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) scores from pre- to post-therapy for the good outcome cases were 30.00 (SD = 5.00) and 4.00 (SD = 1.00) and for the poor outcome cases were 20.67 (SD = 4.93) and 17.67 (SD = 4.51). Note that these cases have also been used for other published case studies (e.g., Honos-Webb, Surko, Stiles & Greenberg, 1999; Honos-Webb, Stiles & Greenberg, 2003).

All six (4 female, 2 males; 5 married, 1 divorced; all Caucasian) clients met diagnostic criteria for major depression (according to the DSM-III-R). Ages ranged from 27 to 63 years old (M = 45.50, SD = 13.78), and they completed an average of 17.50 (SD = 1.87) sessions of therapy.

These six cases involved five (4 female, 1 male; 4 Caucasian, 1 Indian) therapists. The therapists had diverse levels of education (from advanced doctoral students to PhD level clinical psychologists), but all had participated in a 24-week training in EFT using the manual for the York 1 depression study (Greenberg, Rice & Elliott, 1993). This training included eight weeks for CCT, six weeks for systematic evocative unfolding, six weeks for two-chair dialogue, and four weeks for empty-chair dialogue training.

The first author (PhD student in clinical psychology) and six master's level students in clinical psychology coded the therapist skills using the Helping Skills System (HSS). All judges (4 female, 3 male) were Portuguese (English speakers as a second language). Only the first author was aware of the outcome status of each case. None of judges were aware of the results of the IMs coding conducted earlier by Mendes et al. (2010).

3.2. Measures

***3.2.1. The Innovative Moments Coding System* (IMCS; M. Gonçalves et al., 2011)**. includes 5 mutually exclusive categories: action, reflection, protest, reconceptualization and performing change (see descriptions in the Introduction). Validity was inferred given that there were more IMs in good than poor outcome cases (M. Gonçalves et al., 2011). Matos et al. (2009), M. Gonçalves et al. (2011), and Mendes et al. (2010) reported kappas of .89, .97, and .86, respectively, between pairs of judges in categorizations of IM types, indicative of strong agreement (Hill & Lambert, 2004).

***3.2.2. Helping Skills System* (HSS; Hill, 2009).** The HSS is a modification of the Hill Counselor Verbal Response Category System (HCVRCS; Hill, 1978, 1986), which Hill, Nutt, and Jackson (1994) cited as the most widely used response modes system. The HSS is relatively easy to learn and use reliably. It includes 12 nominal, mutually exclusive categories of therapist verbal behavior, which can be organized into three larger categories: *exploration* (includes approval and reassurance, closed questions, open questions, restatements and reflections of feeling), *insight* (includes

challenges, interpretations, self-disclosure and immediacy), and *action* (includes information and direct guidance). The HSS also includes an *other* category for therapist statements that are unrelated to client's problems or issues (e.g., salutations or small talk).

Hill (1978) established content validity for the HCVRCS by combining categories from existing measures and having experts from different theoretical orientations determine the representativeness of categories. Concurrent validity was established through high associations with similar categories on other response mode systems (Elliott, Hill, Stiles, Mahrer, & Margison, 1987). For the current version of the HSS, an average kappa of .91 between pairs of judges was reported by Hess, Knox, and Hill (2006) for judgments of all response units (i.e., sentences), and .98 by Goates-Jones et al. (2009) for predominant units (the most salient unit within a therapist speaking turn). In the present study, the average kappa between pairs of judges for predominant units was .80.

3.3. Procedures

In the present study, we used the first two sessions, two sequential middle sessions, and the two final sessions from each of the six cases. These sessions had all been coded previously with the IMCS by Mendes et al. (2010).

All judges were first trained by the first author to unitize therapist speech into response units (essentially grammatical sentences), using rules adapted by Hill (2009) from Auld and White (1956). This training continued until all the raters reached a minimum of 90% agreement in the independent unitizing of a session. After training, judges independently unitized all the therapist speech in the 36 sessions, attaining an agreement level of 94%. Then, rotating teams of three judges, with the first author serving on all teams, met to reach consensus regarding discrepancies and to then select the predominant unit (defined as the unit that, when compared to the other response units in that therapist turn, has the most impact in the following client response) within speaking turns. Teams used consensus (Hill, Thompson, & Williams, 1997) to identify the 4991 predominant units.

Once unitizing was completed, the judges were trained, using sessions not included in the present study, by the first author to use the HSS until they reached a minimum kappa of .75 (strong agreement level, Hill & Lambert, 2004) between all pairs of judges. The unitizing and coding training took six months.

After training, all the therapist units in each session were independently coded into 1 of the 12 categories of the HSS by rotating teams of three judges. Judgments of two of the three judges were accepted as the master coding; three-way discrepancies were resolved through consensus. For data analyses, we clustered the data into the larger categories of exploration, insight, or action skills. We then divided the skills into those that were used immediately preceding or during IMs versus skills that preceded or were used during non-IMs.

4. RESULTS

Table I. 1: Examples of helping skills in EFT

HELPING SKILLS	Description	Examples in EFT
	EXPLORATION INTERVENTIONS	
1. Approval/ reassurance	Provides simple encouragement, reinforcement or emotional support.	*T: I understand.*
2. Closed question	Request information/clarification, with a simple yes or no answer from the client.	*T: Do you agree with what she said?*
3. Open question	Ask clients to elaborate further or to explore more.	*T: How are you?*
4. Restatement	Rephrases what the client said, in regards to content or meaning, trying to increase clarity.	*T: So going out of the house allows you to put that aside for the time being.*
5. Reflection of feelings	Rephrases what the client said in terms of the exploration of feelings or attempts to identify/infer client's feelings.	*T: It seems painful for you to talk about this situation.*
	INSIGHT INTERVENTIONS	
6. Challenge	Highlights discrepancies, contradictions, irrational beliefs and conflicts that the client is unaware of or unwilling to change.	*T: You seem to trivialize this, but a part of you is feeling resentful.*
7. Interpretation	Goes beyond what the client said and tries to give/promote other meanings, explanations, or reasons for behaviors, thoughts and feelings.	*Therapist:* So that's where you are then, trying to understand. / You're the person they go to. / *You're the one who should accept things and not make a big deal out of things***.** / Sounds like, sounds like that's a lot. /
8. Self-disclosure	Reveals something personal about the therapist that transcends the immediate feelings and the here-and-now of the therapeutic encounter.	**No self-disclosures were found in this sample.**
9. Immediacy	Specific disclosure of therapist's immediate feelings and thoughts in relation to the self, the client, or therapeutic relationship.	*T: I also have a lot of admiration for you because I think you're very strong.*
	ACTION INTERVENTIONS	
10. Information	Concerns facts or data on the therapy (like its structure or efficacy) and feedback on the client.	*T: I guess you're aware of forms that you have to fill after* (the session).
11. Direct guidance	Provides suggestions, instructions or advice about the therapeutic process or problem solving strategies.	*T: Tell her how it felt to hear that from her.*
	OTHER	
12. Other	Therapist's statements unrelated to the therapeutic process or client issues, such as salutations or small talk.	*T: Let me get you some Kleenex outside.*

4.1. Therapist skills used in EFT

Table I.1 shows examples from the current study for each skill. Table I.2 shows the proportions of predominant skills used in the initial, middle, and final phases of good (GO) and poor (PO) outcome cases.

Table I. 2: Proportion of therapist skills

	POOR OUTCOME				GOOD OUTCOME			
INTERVENTION CATEGORIES	INITIAL PHASE	MIDDLE PHASE	FINAL PHASE	*GLOBAL USE*	INITIAL PHASE	MIDDLE PHASE	FINAL PHASE	*GLOBAL USE*
EXPLORATION SKILLS	79%	65%	62%	*69%*	83%	83%	79%	*80%*
Probability estimates for exploration interventions	0.7867	0.6510	0.6182		0.8253*	0.7847*	0.7819*	
INSIGHT SKILLS	16%	19%	18%	*17%*	6%	5%	13%	*8%*
Probability estimates for insight interventions	0.1556*	0.1865*	0.1781*		0.0671	0.0590	0.1177	
ACTION SKILLS	5%	15%	18%	*13%*	10%	12%	7%	*11%*
Probability estimates for action interventions	0.0562	0.1528	0.1764*		0.0937*	0.1544	0.0886	

Notes:
* Statistically significant difference at the p<.05 level in inter-group comparison on the same phase

To determine if there were statistically significant differences in the use of each therapist skill in the two outcome groups, we used a multinomial generalized mixed effects model (Agresti, 2002) so that we could estimate the probability of each skill according to therapy phase (initial, middle, final) and type of outcome (GO or PO). We considered type of outcome (GO or PO) as an explanatory variable and assumed that the probability of each skill was a random variable with a Bernoulli distribution. We also included a subject specific random effect to take variability among individuals into account given that we expected that measurements (interventions) from the same participant (therapist) would be correlated.

We then assumed, according to Agresti (2002), that the probability of occurrence of a given skill was a conditional function of *type of outcome* and *therapy phase*, where the explanatory variables have a linear effect on the probability through a link function (i.e., a logarithmic function that allows outcomes to be between 0 and

1, see Agresti, 2002, for more details). The explanatory variables (type of outcome and therapy phase) were then included to arrive at a vector of the parameters (probabilities of each therapist skill). When fitting the data to this model, we ended up with the selected linear model (adjusted for each skill type), shown in the following equation (using exploration skills as the example):

Probability (of exploration interventions | explanatory variables) = $\frac{\exp(L_1)}{\sum_{i=1}^{4} L_i}$

Where,

$$L_1 = \beta_1 If(poor\ outcome) + \beta_2 If(good\ outcome) +$$
$$+\beta_3 If(poor\ outcome, middle\ phase) + \beta_4 If(poor\ outcome, final\ phase) +$$
$$+\beta_5 If(good\ outcome, middle\ phase) + \beta_6 If(good\ outcome, final\ phase)$$

($\boldsymbol{\beta} = (\beta_1, \beta_2, \beta_3, \beta_4, \beta_5, \beta_6)$ is the vector of the parameters to estimate)

In this model we contrasted the probability of exploration, insight and action skills against the "other" category (but we do not report the results for the "other" category).

Results of this analysis show that exploration skills were used significantly more often in GO than PO cases in all phases of therapy (table 2). In contrast, insight was used significantly more often in PO than in GO cases in all phases of therapy. Finally, action skills were used significantly more often in the initial phase of GO than PO cases, but significantly more often in the final phase of PO cases than GO cases.

4.2. The association between therapist skills and overall IMs

Essentially, we did sequential analyses of how often an IM (of any type) followed or did not follow each of the three types of therapist skills. More specifically, we used a binomial generalized linear mixed (GLM) effects model (Agresti, 2002) to estimate the probability of IMs following the three therapist skills

(exploration, insight, action) according to therapy phase (initial, middle, final), and type of outcome (GO or PO). In this GLM, we considered the binary response of IM occurring or not occurring as a random variable with Bernoulli distribution to make an inference on the probability parameter associated to this distribution. We also used a subject specific random effect to take variability among individuals into account. We assumed that the probability of an IM occurring was a conditional function of *type of outcome*, *therapist skill,* and *therapy phase*, where the explanatory variables have a linear effect on the probability, through a link function. The explanatory variables (type of outcome, therapist skills, and therapy phase) were included to arrive at a vector of the parameters (probability of an IM occurring). We ended up with the selected linear model (which includes only the significant variables), using the following equation (where b is the vector of the parameters to estimate):

$$\text{Probability (of IM} \mid \text{explanatory variables)} = \frac{\exp(\theta)}{1+\exp(\theta)}$$

Where

$$\begin{aligned}\theta &= \beta_1 \text{If(poor outcome)} + \beta_2 \text{If(good outcome)} + \\ &+ \beta_3 \text{If(poor outcome, middle phase)} + \beta_4 \text{If(poor outcome, final phase)} \\ &+ \beta_5 \text{If(good outcome, middle phase)} + \beta_6 \text{If(good outcome, final phase)} \\ &+ \beta_7 \text{If(Exploration intervention)} + \beta_8 \text{If(Action intervention)}\end{aligned}$$

($\boldsymbol{\beta} = (\beta_1, \beta_2, \beta_3, \beta_4, \beta_5, \beta_6, \beta_7, \beta_8)$ is the vector of the parameters to estimate)

The estimated probabilities of IMs following each skill category are shown in Table I. 3 and Figure I. 1. IMs more often followed skills in GO than PO cases. There are no differences between the three types of skills and the production of IMs in either the GO or PO cases. In terms of phase of therapy for PO cases, IMs more often followed all skills in middle than initial or final phases. Thus, the association of skills with IMs increased from the initial to the middle phase of therapy, but then decreased from the middle to the final phase. In contrast, for the GO cases, IMs more often followed skills in the middle and final phases than in the initial phase. That is, the

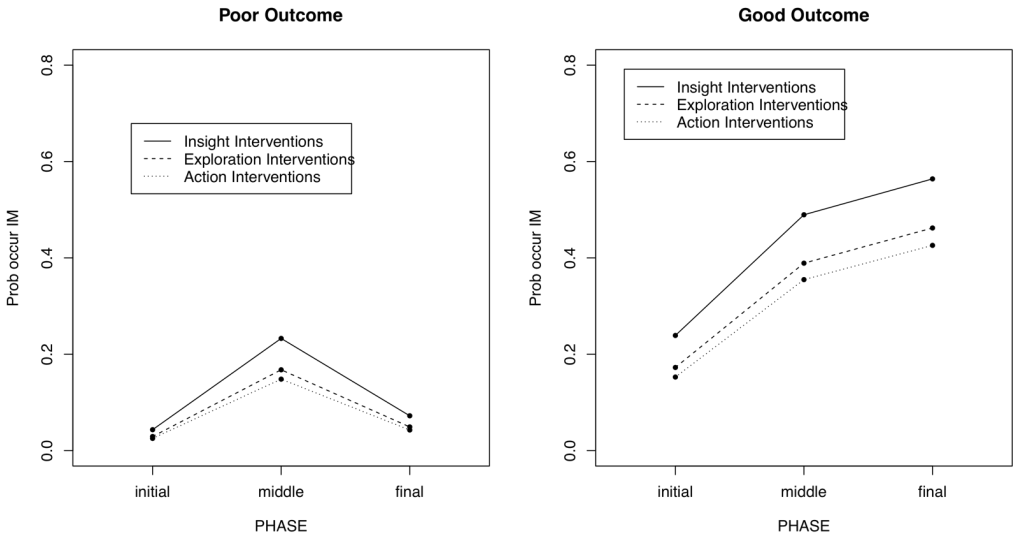
association of skills with IMs increased from the initial to the middle phase, and then maintained the same level from the middle to the final phase (see figure I – 1).

Table I. 3: Association between therapist skills and total IMs

		POOR OUTCOME			GOOD OUTCOME		
PHASE		**EXPLORATION INTERV.**	**INSIGHT INTERV.**	**ACTION INTERV.**	**EXPLORATION INTERV.**	**INSIGHT INTERV.**	**ACTION INTERV.**
INITIAL							
	Followed by IMs	20	1	0	145	12	6
	Not followed by IMs	526	107	39	630	41	82
	Probability estimates of IM occurring	*0.0293*	*0.0437*	*0.0254*	*0.1726**	*0.2390**	*0.1527**
MIDDLE							
	Followed by IMs	83	38	27	298	28	74
	Not followed by IMs	278	117	100	500	32	66
	Probability estimates of IM occurring	*0.1678 °*	*0.2329 °*	*0.1483 °*	*0.3890*°*	*0.4895*°*	*0.3549*°*
FINAL							
	Followed by IMs	22	3	3	343	71	20
	Not followed by IMs	81	101	100	381	38	62
	Probability estimates of IM occurring	*0.0492 °*	*0.0723 °*	*0.0428 °*	*0.4620**	*0.5639*°*	*0.4259**

Notes:
* Statistically significant difference at the p<.05 level in inter-group comparison on the same phase
° Statistically significant difference at the p<.05 level in intra-group comparison to the previous phase

Figure I. 1: Probability of an IM occurring after each therapist skill



4.3. The association between therapist skills and different types of IMs

We also investigated the probabilities of specific types of IMs following specific therapist skills in the three phases for the two outcome groups. For this analysis, we combined action, reflection and protest IMs into one category henceforth called ARP IMs, and reconceptualization and performing change IMs into a second category henceforth called RCPC IMs (see the rationale for this in the introduction).

For this analysis we used a multinomial GLM mixed effects model (Agresti, 2002) to estimate the probability of the occurrence of ARP IMs versus RCPC IMs according to skills (exploration, insight, action), therapy phase (initial, middle, final) and type of outcome (GO or PO). We used the same model for the expected value as was used for the previous model of total IMs, with two additional probabilities to estimate the occurrence of ARP or RCPC IMs at each phase for each outcome:

$$\text{Probability (occurring ARP IMs| explanatory variables)} = \frac{\exp(\theta_1)}{1+\exp(\theta_1)+\exp(\theta_2)}$$

$$\text{Probability (occurring RCPC IMs| explanatory variables)} = \frac{\exp(\theta_1)}{1+\exp(\theta_1)+\exp(\theta_2)}$$

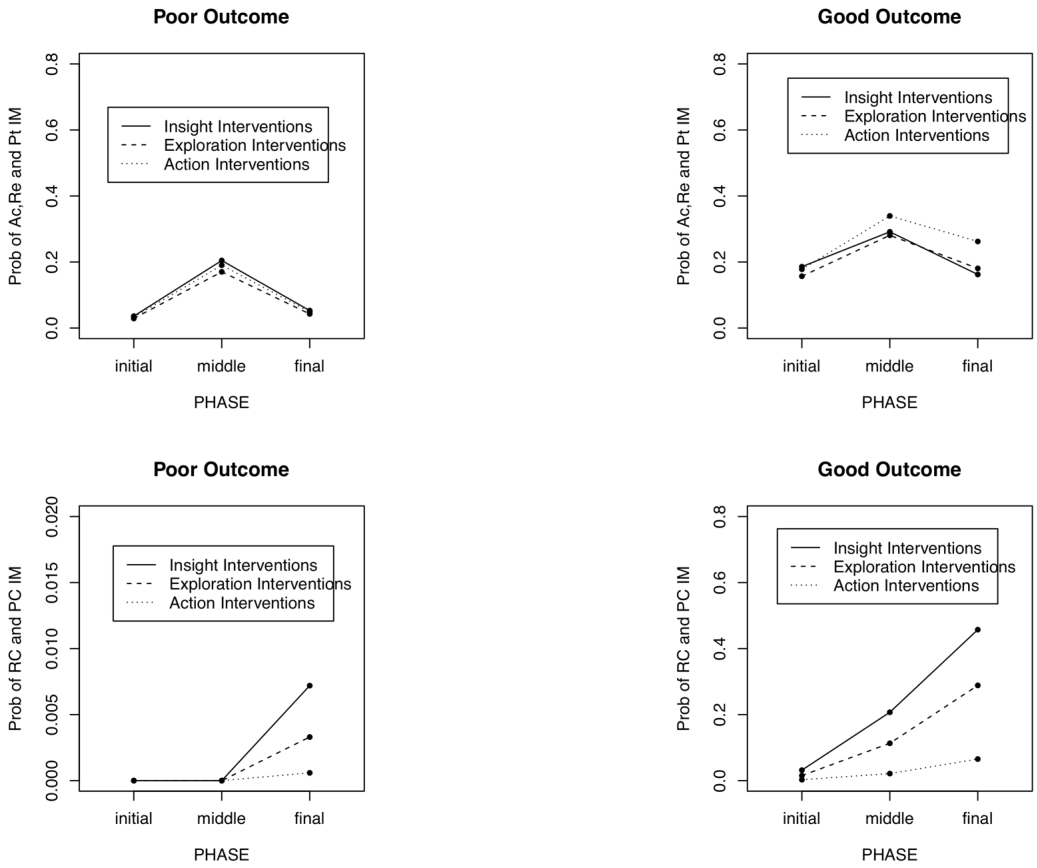
The results are shown in Table I. 4 and Figure I. 2. Overall, both ARP IMs and RCPC IMs followed skills more often in GO than PO cases for all phases of therapy.

We also analyzed the probabilities of skills occurring with different types of IMs within treatment phases (that is, comparing lines with one another within treatment phases in Table I. 4). In the final phase for the PO cases, all skills were more often associated with ARP IMs than with RCPC IMs. In the GO cases in both the initial and middle phase, all 3 skills were more often associated with ARP IMs than RCPC IMs, whereas in the final phase exploration and insight were more often associated with RCPC IMs than ARP IMs, whereas action skills were more often associated with ARP than RCPC IMs.

Table I. 4: The association between therapist skills and ARP IMs and RCPC IMs

		POOR OUTCOME			GOOD OUTCOME		
PHASE		**EXPLORATION INTERV.**	**INSIGHT INTERV.**	**ACTION INTERV.**	**EXPLORATION INTERV.**	**INSIGHT INTERV.**	**ACTION INTERV.**
INITIAL							
	Probability of ARP IMs	*0.0290*	*0.0361*	*0.0331*	*0.1569**	*0.1859*°*	*0.1780*°*
	Probability of RCPC IMs	*0.000*	*0.000*	*0.000*	*0.0152**	*0.0317**	*0.0027**
MIDDLE							
	Probability of ARP IMs	*0.1703*	*0.2046*	*0.1904*	*0.2809*°*	*0.2915*°*	*0.3396*°*
	Probability of RCPC IMs	*0.000*	*0.000*	*0.000*	*0.1131*°*	*0.2070*°*	*0.0213*°*
FINAL							
	Probability of ARP IMs	*0.0428*	*0.0529*	*0.0489*	*0.1807*°*	*0.1623*°*	*0.2623**
	Probability of RCPC IMs	*0.033 °*	*0.0072 °*	*0.0006 °*	*0.2884*°*	*0.4572*°*	*0.0653**

Figure I. 2: Probabilities of therapist skills on ARP IMs and RCPC IMs



5. DISCUSSION

In this study, we investigated the effectiveness of exploration, insight, and action skills as used by EFT therapists to treat clients with depression. As a measure of treatment (big o) outcome, we looked at differences between good and poor outcome cases (which was justified because there were more IMs in GO than PO cases). As a measure of immediate (little o) outcome, we looked at which therapist skills were immediately followed by IMs. We found evidence for the effectiveness of all skills, and discuss these results more completely in this section.

5.1. Effects of skills

The skills preceded IMs more often in GO than PO cases, providing validity both for the designation of good versus poor cases as well as for the association

between skills and IMs. Moreover, the skills often preceded IMs in the middle phase of treatment in both GO and PO cases, as well as in the final phase of treatment for the GO (but not PO) cases. These results suggest that the middle phase of therapy is particularly important as a working phase of EFT, and also suggests that the connection between skills and IMs persists more in GO than PO cases. Thus, therapist skills do make a difference in EFT treatment of depression, which supports the propositions of Gelso (2005), Goldfried and Davila (2005), and Hill (2005) that therapist skills make a difference but that this effect can only be shown if skills are studied within the context of individual dyads within different phases of therapy.

5.2. Exploration skills

The vast majority of skills used in both GO and PO cases were exploration skills, but exploration skills were used more often in all phases of therapy in GO (79 to 83%) than PO cases (62 to 79%), suggesting that exploration skills are particularly helpful skills in EFT. The use of exploration skills is consistent with the client-centered stance of EFT (Greenberg, 2006; Greenberg, Rice & Elliott, 1993; Pos & Greenberg, 2007) that encourages the client to be the active agent of change.

Although exploration skills occurred most frequently, it is important to note that they were no more likely to lead to overall IMs than were insight or action skills. In fact, there are no significant differences in the association between different skills and overall IMs. There was, however, an interesting finding that exploration (and insight) skills preceded ARP skills more often than RCPC IMs in the initial and middle phases, but more often preceded RCPC than ARP IMs in the final phase, in GO cases. This is consistent with the theoretical model of change suggested by M. Gonçalves et al. (2009), given that ARP IMs (lower level types) are typical of the initial and middle stages of treatment, while RCPC IMs (higher level types) are more typical of middle and final stages and, as these findings show, these are mainly produced by exploration (and insight skills) at the final treatment phase. These results suggest that exploration skills elicit the more complex IMs only later in therapy once the foundation has been set with the simpler IMs, as suggested in M. Gonçalves et al. (2009) model. Therefore, the current findings highlight the importance of exploration skills in EFT, which again is consistent to the theory of this therapy.

5.3. Insight skills

Insight skills were used far less often than exploration skills, reflecting EFT's eschewal of therapists offering insight. Moreover, insight skills were used more often in all phases of PO (16 to 19%) in contrast with GO cases (6 to 13%). We speculate that in PO cases therapists were trying to find some way to help the clients when the more typically prescribed exploration skills were not working.

In addition, as described above, insight skills functioned in a similar way as exploration skills in terms of eliciting different types of IMs in the three phases of therapy. That is, they also appear linked to the production of ARP IMs in the initial and middle phases and to the production of RCPC IMs in the final phase of therapy. These results echo Hill and Kellems (2002) findings of the difficulty of separating exploration and insight skills, given that even though they can be distinguished theoretically, they often have the same impacts.

Hence, although EFT theory downplays the role of insight skills, the current findings provide some support for the idea that the promotion of insight seems to be an important feature of good outcome therapy (see Castonguay & Hill, 2007), regardless of the model. However, given the exploratory nature of this study – in our knowledge, the first to apply the HSS in EFT – such findings on insight skills need further understanding and empirical support.

An interesting direction for future studies would be to carry out an intensive look at the content of the specific skills (interpretations, challenges and immediacy) that constitute this category. Up until now, a thorough research review on experiential therapies made by Elliott, Greenberg and Lietaer (2004), lead these authors to conclude that not only insight interventions have been unexpectedly found in humanistic and experiential models but also that some studies link them to significant client in-session changes (see, for example, Gazzola & Stalikas, 1997). And as some authors also within the experiential tradition have emphasized, the promotion of *experiential insight* (a low-level abstraction, experience-near, lived understanding of what is happening (e.g., Pascual-Leone & Greenberg, 2007b) is also an important aspect of EFT and the attainment of this goal may sometimes require therapists to go beyond and further than where the client is at the present-moment (through insight skills).

5.4. Action skills

In GO cases, action skills were used about 10% to 12% of the time in the initial and middle phases but used only 7% of the time in the final phases of GO cases. We speculate that action skills were used a lot throughout the beginning and middle of GO cases because the therapist and client were engaging actively in EFT tasks such as empty chair work which involves a very directive and active therapeutic approach. But as therapy winds down, therapists shift away from this intense directive work and perhaps help clients to consolidate their gains. In contrast, in the PO cases, action steadily increased (5%, 15%, 18%) across phases. We speculate that therapists were not able to engage clients as readily in the therapeutic tasks in the PO cases and then kept trying to engage them later when it may have been too late.

Furthermore, action skills were more often associated with ARP than RCPC IMs in GO cases. This association is clearer, in the final phase of therapy, suggesting that the emergence of these IMs still continues to be important at this stage. We have suggested before that these IMs could interact with RCPC IMs, further stimulating the occurrence of these higher level IMs. That is, as clients narrate a different story of themselves (reconceptualization and performing change IMs), specific actions, thoughts and feelings (ARP IMs) that are congruent with the former still occur and further contribute to change.

However, although action skills can be used to facilitate lower level IMs, they seem less efficient in helping clients attain the higher level IMs. Thus, although EFT therapists use action skills to direct clients to engage in therapeutic tasks especially within the middle phase of therapy, it appears that they also need to use exploration and insight skills to promote the higher level IMs later in therapy.

6. LIMITATIONS AND IMPLICATIONS

One major limitation is the small sample of six cases chosen to represent good and poor EFT cases. Because these cases represent only five therapists all trained by the developers of EFT, results may not generalize to other therapists. And of course the findings are limited to clients who have depression and who are willing to participate in research.

Another limitation is that the system for coding therapist skills is pantheoretical rather than having been developed specifically for EFT; thus, it may

not be sensitive to highlighting the unique skills used in EFT (see Elliot et al., 2004, for details about a coding system developed specifically for EFT). Such aspect can account for the unexpected findings regarding the use of insight skills and their relation to IMs. We would argue, however, that using a pantheoretical system is important for producing results that apply to all therapeutic approaches.

A third limitation involves the use of the little o and big o outcome measures, which may not completely capture the outcomes of therapist skills. Immediate impacts may not show up either in the next client speaking turn but rather may be variable and delayed for different clients. As Elliott (2010) noted, sequential analysis does not allow researchers to expand the analysis beyond the relationship between preceding interventions and their immediate outcomes. For example, the use of a particular intervention in a given situation can be related to the therapist assessment of the level of experiencing of the client in that particular moment in therapy (Gordon & Toukmanian, 2002), which can act as a third variable mediating the interaction between interventions and the client's immediate reaction. In terms of big o outcome, other therapist and client variables can account for differences in outcome in addition to therapist skills.

We are also aware that the use of this research design does not acknowledge that in therapy, as in human interaction in general, communication is responsive to the people involved in a given situation (Stiles, Honos-Webb & Surko, 1998). In other words, what a therapist says, and how it is said, is certainly more complex than what these methods can capture and describe. Still, this study yielded findings that can be useful as long as we recognize that they represent only one dimension of therapist and client talk abstracted from the multilayered phenomena of therapeutic interaction (De Stefano, et al., 2001; Hill, 2005).

In terms of practice and training, these findings suggest the crucial need for therapists to pay attention to the immediate outcomes of their specific interventions, to note for example whether their exploration and insight skills indeed lead to clients having innovative moments. Thus, therapists need to be scientists, reviewing recordings of their sessions to determine whether their interventions are leading to clients behaving in new ways.

In terms of future research, it would be interesting to extend these findings to good and poor outcome cases of other theoretical approaches and client types. It would also be interesting to expand the sequences beyond one lag (immediate effects

of therapist skills) to determine if some of the effects might be systematic but delayed. Furthermore, future studies privileging an intensive look at insight skills present in EFT should highlight if and how these findings might cohere with the EFT model and facilitate the contrast between traditional forms of promoting insight in therapy and the promotion of experiential insight in EFT. We also encourage researchers to think of other ways to examine the effects of therapist interventions.

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CHAPTER II

REHEARSING RENEWAL OF IDENTITY: RECONCEPTUALIZATION ON THE MOVE

CHAPTER II

REHEARSING RENEWAL OF IDENTITY: RECONCEPTUALIZATION ON THE MOVE[4]

1. INTRODUCTION TO STUDY 2

The self is both stable and ever in motion and it is shaped by a person's telling of stories – to oneself and to others. In fact, the telling of a life story is an act that allows the creation of a stable, yet changing, image of oneself. From this metaphor of people as storytellers (Bruner, 1990; McAdams, 1993; Sarbin, 1986), we have been developing a research program that tracks the emergence of novelties in people's lives, trying to figure out the transformation process of self-narratives (see Gonçalves, Matos & Santos, 2009; Gonçalves, Mendes, Cruz, A. Ribeiro, Angus & Greenberg, 2011). For this purpose we created a coding system – the Innovative Moments Coding System (Gonçalves, A. Ribeiro, Matos, Santos & Mendes, in press) – that allows the tracking of novelties, which emerge in discourse, called innovative moments (or IMs). IMs are exceptions to a dominant self-narrative. Whereas the dominant self-narrative is the rule (of behaving, feeling, thinking), IMs are the exceptions (like new actions, feelings, thoughts or intentions, for example). According to this model of narrative change (Gonçalves et al., 2009) the expansion of these exceptions are central in self-narrative transformation. People' self-narratives are stabilized around a dominant framework, in which a voice or a coalition of voices is occupying the narrator's position. Every time a meaningful change occurs in this dominant framework, alternative voices – new ones or previously dominated – come to the foreground, occupying the role of narrators. Thus, we conceive IMs as non-dominant voices that have the potential to disrupt a previously dominant self-narrative (see Gonçalves & A. Ribeiro, in press, for an elaboration of the dialogical processes involved in self-narrative transformations).

Often in psychotherapy – our main domain of research – dominant self-narratives become so overriding that they exclude all alternatives, becoming reduced to a "single

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[4] This chapter has the following authors: Carla Cunha, Miguel M. Gonçalves, Jaan Valsiner, Inês Mendes, & António P. Ribeiro and is currently in press to appear in the upcoming book by: Bertau, M. C., Gonçalves, M. M., & Raggat, P. (Eds.) (forthcoming). The development of the dialogical self: Advances in cultural psychology (series editor: Jaan Valsiner). Charlotte, N.C., USA: IAP, Information Age Publications. We are very grateful to Lynne Angus and Leslie S. Greenberg for allowing us to analyze and use these transcripts.

theme" (Hermans & Hermans-Jansen, 1995, p. 164). In this sense, dysfunctional self-narratives are more close to a monological outcome since they exclude dialogical alternatives.

1.1. Innovative moments as resistance to monological narratives: A conceptual model

Before we proceed, we will briefly summarize our main findings using the Innovative Moments Coding System to study psychotherapy. These findings emerged from the study of psychotherapy samples (Gonçalves, Mendes et al., 2010; Matos, Santos, Gonçalves & Martins, 2009; Mendes, et al., 2010) and intensive cases-studies (Gonçalves, Mendes, et al., 2010; A. Ribeiro, Bento, Salgado, Stiles & Gonçalves, 2011; Santos, Gonçalves, Matos & Salvatore; 2009). The transformation of self-narratives involves IMs' emergence and expansion, in a clear patterned way that is visible in successful cases of psychotherapy (Gonçalves et al., 2009; Gonçalves, Santos et al., 2010). The first signs of change are made evident from the emergence of three types of IMs: action, reflection and protest (see table II.1).

Action IMs refer to single actions in which the person challenges the dominance of the previous self-narrative; that is, the person acts in a way somehow not predicted by the dominant narrative. Reflection IMs refer to cognitive products that represent exceptions to the way the dominant self-narrative leads the person to think (this can emerge in the form of thoughts, fantasies, intentions, and so on). Finally, protest IMs could be an action or a thought but represent a more proactive way to refuse the dominant self-narrative. The person enacts, with protest IMs, an attitudinal refusal of the assumptions of the previous dominant self-narrative. The sequence of these three types varies. In some cases, the person starts with action IMs, acting in a way that challenges the former dominant narrative and from here reflection or protest IMs, that are congruent with these actions, emerge. Other times action almost does not emerge and change starts mainly from protest and reflection IMs. Finally, in some cases, change starts with reflection and only after some elaboration of these IMs, protest appears and develops.

Table II. 1: Innovative Moments and examples from Emotion-Focused Therapy

Types of Innovative Moments	Examples from Emotion-Focused Therapy (Problematic narrative: depression)
ACTION INNOVATIVE MOMENTS	
Action IMs refer to events or episodes when the person acted in a way that is contrary to the problematic self-narrative.	*C: I actually took a step the other night and I let my husband know that I thought that my workload was a lot more that his was and that we should share our things more evenly.*
REFLECTION INNOVATIVE MOMENTS	
Reflection IMs refer to new understandings or thoughts that undermine the dominance of the problematic self-narrative. They can involve a cognitive challenge to the problem or cultural norms and practices that sustain it or new insights and understandings about the problem or problem supporters. These IMs frequently can also assume the form of new perspectives or insights upon the self while relating to the problem, which contradict the problematic self-narrative.	*C: Yeah, because I think that this still affects me now a lot of times… Like I don't really have the courage to come forward with things because I just expect not being heard or people not to being able to relate to it or understand it. So, rather than trying, I'm just so afraid of getting the same treatment, the rejection that I just remain in the same mode I constructed back then.* *T: Right, so it's almost a general thing now – that's how you were treated then and now it's almost an expectation that that's how you'll be treated now?* *C: Yeah.*
PROTEST INNOVATIVE MOMENTS	
Protest IMs involve moments of critique, confrontation or antagonism towards the problem and its specifications and implications or people that support it. They can be directed at others or at the self. Oppositions of this sort can either take the form of actions (achieved or planned), thoughts or emotions, but necessarily imply an active form of resistance, repositioning the client in a more proactive confrontation to the problem (which does not happen in the previous action and reflection IMs). Thus, this type of IMs entails two positions in the self: one that supports the problematic self-narrative and another that challenges it. These IMs are coded when the second position acquires more power than the first.	*C: I don´t like you gambling your money, because you work hard for it. I want you to put an effort on trying to solve your problems instead of just shoving them under the carpet or denying it.* *T: I want you to look at your problems.* *C: Yeah, I want you to look at your problems, I believe I´m doing my part and I want you to do yours!* *T: What do you feel towards him?* *C: There, there is a demand. Umm, I'm angry with him.* *T: Tell him about being angry.* *C: Yeah, I´m mad at you. I´m mad at you!*
RECONCEPTUALIZATION INNOVATIVE MOMENTS	
Reconceptualization IMs always involve two dimensions: a) a description of the shift between two positions (past and present) and b) the transformation process that underlies this shift. In this type of IMs there is the recognition of a contrast between the past and the present in terms of change, and also the ability to describe the processes that lead to that transformation. In other words, not only is the client capable of noticing something new, but also capable of recognizing oneself as different when compared to the past due to a transformation process that happened in between.	*C: I've been, you know, just pretty well. Again, I'm more expressing my feelings now towards things, I find…* *T: Yeah, that's good.* *C: So that's a change for me.* *T: Yeah* *C: And it feels good after I do that because it's, it's important you know* *T: Yeah, you feel good when you do it* *C: Yeah, it should be expressed. I shouldn't have to hold all that in me, so that makes me feel more power, you know, more in control of things* *T: Yeah. So in general you feel more in control and* *C: yeah* *T: you're saying it's related to expressing your feelings.* *C: That's right, yeah. I've been feeling much less helpless or weak or* *T: Hh-huh. You feel stronger when you say what you want.* *C: Right, when I when I do that, yeah.*

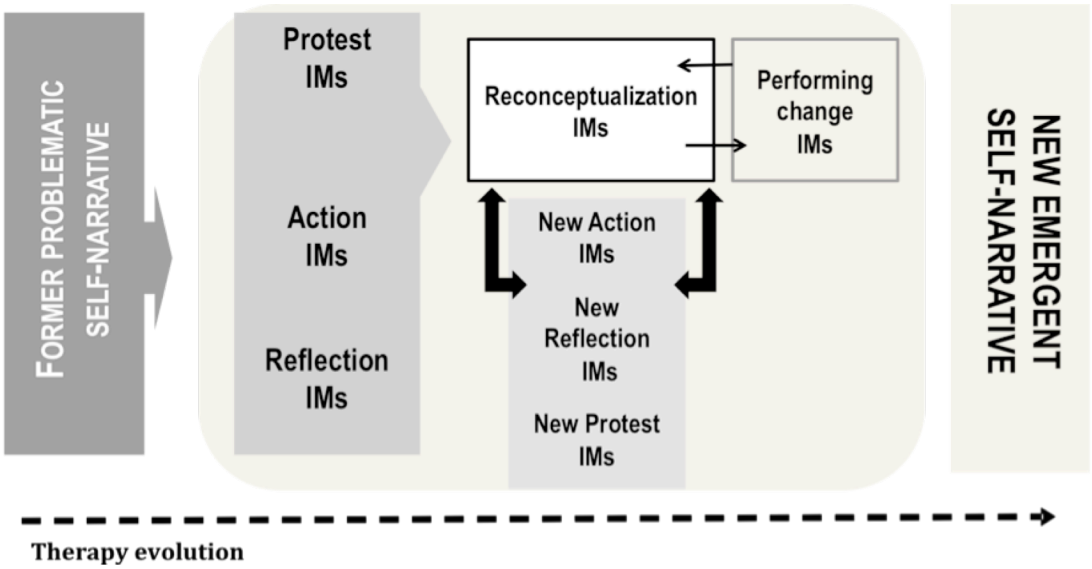
PERFORMING CHANGE INNOVATIVE MOMENTS	
Performing change IMs refer to new aims, projects, activities or experiences (anticipated or already acted) that become possible because of the acquired changes. Clients may apply new abilities and resources to daily life or retrieve old plans or intentions postponed due to the dominance of the problem.	*C: ... but I was able to actually bring up the subject and talk to him about it, as before in the past I was afraid to say something because he'd take it the wrong way, or he'd take it as sort of an attack to him.* *T: So you're feeling kind of more freed up, it sounds* *C: Yes* *T: like to be able to bring up things with him* *C: mm-hm* *T: and talk about things. A lot more, kind of less afraid, less cautious about approaching him.* *C: Mm-hm, right.*

After some elaboration of these three types of IMs (action, reflection and protest), reconceptualization IMs (see table II.1) emerge and become the dominant IM type in successful psychotherapy. In reconceptualization IMs, the person not only narrates a change between a past and a present condition (*before I was X, now I'm feeling Y*), but also describes the process that allowed this transition. Dialogically, reconceptualization involves what Hermans (2003) calls a metaposition that frequently acts as a trigger of innovation in the self (e.g. Hermans & Kempen, 1993). This concept can be defined as "… a perspective from which the client phrases the linkages between several significant positions in a self-reflective way." (Hermans & Hermans-Jansen, 2004, p. 133)

Finally, performing change IMs emerge in the process. These are projections into the future (e.g., plans, projects) about the change that is occurring. This process is depicted in figure II.1.

Thus, reconceptualization IMs seem to be a very powerful type of innovation in the path to a new self-narrative. Several findings support this claim. First, they are almost absent (or even completely absent) in unsuccessful psychotherapy (Gonçalves et al., 2009; Gonçalves, Mendes et al., 2010; Matos et al., 2009; Mendes et al., 2010). Second, they increase their emergence from the middle to the end of psychotherapy and are clearly necessary to stabilize emerging changes. Third, reconceptualization keeps repeating itself, which means that the person does not change after the first reconceptualization but needs some consolidation of these IMs that requires a working through in the perspective conveyed by this meta-position in order to strengthen the change process (we will return to this later on).

Figure II. 1: A heuristic model of psychotherapy change in the perspective of innovative moments (Gonçalves, Matos & Santos, 2009)



We have also proposed (Gonçalves et al., 2009; Gonçalves & A. Ribeiro, in press; Ribeiro, Bento, Gonçalves & Salgado, 2011) that when reconceptualization does not emerge, or appears only in an incipient way, the person is often caught in a vicious circle called mutual in-feeding (Valsiner, 2002). In this process IMs emerge but are soon aborted by the re-emergence of a problematic voice (e.g. "*I would like to feel more confident to express myself* [IM], *but I am afraid others will not like me that way* [re-emergence of the problematic voice]"). Mutual in-feeding is a process that maintains stability in the self by displaying a redundant circularity between contrasting voices that follow each other, where the last immediately counteracts the first[5] (Valsiner, 2002).

Our focus in this chapter is to understand how the reconceptualization process leads to successful change. More specifically, we can ask: *How and why these narratives reflect the developing process of self-narratives during therapy evolution?* And also *how does the therapist participate in the process of facilitating these changes and restoring self-continuity in the client?* Consequently, this chapter represents a theory-building

[5] This circularity between voices or positions in the case of mutual in-feeding is frequently achieved through the use of circumvention strategies. These discursive devices change the outcome of the person's meaning making (or conduct and feelings) regardless of the initial direction, regulating opposing or ambiguous meanings through a return to an original more familiar position (Josephs & Valsiner, 1998).

effort through the intensive analysis of a single case-study (Stiles, 2007). There are two aims: i) to explore the emergence and changing quality of reconceptualization IMs in psychotherapy, trying to further understand the function of these IMs in the ongoing development of a new self-narrative; and also ii) to address how the therapist can facilitate this narrative shift.

1.2. Grasping transitions in the self through reconceptualization

We believe that several ingredients of reconceptualization are central in transforming self-narratives. We will explore three theoretical arguments to justify our claim. First, through reconceptualization, the other IMs can become integrated in a more complex narrative that provides a sense of direction towards change. This calls for a new sense of agency and authorship, consolidating a broader and integrative view of the developing self in time (a synthesis in the self – Hermans & Kempen, 1993; see also Santos & Gonçalves, 2009).

Second, as we stated before, reconceptualization IMs highlight the adoption of a meta-perspective stance in the self that allows the person to become aware of a transformation process (i.e., Here-And-Now contrasted with There-In-the Past) and to depict a differentiation between alternative self-versions (i.e., Self-As-Was and Self-As-Is). This meta-perspective refers to the key ability to take a step-back and adopt a metaposition towards the problematic experience (Hermans & Kempen, 1993, referred to also as an observer position – Leiman & Stiles, 2001). This creates a psychological distance that facilitates a retrospective observation and reflection upon oneself while reacting in a problematic situation. More broadly, this process converges also with the importance attributed to the concept of insight in the promotion of change (e.g. Castonguay & Hill, 2007) and also with the role played by metacognition in the change process, another concept that has received growing attention in the psychological literature (e.g. Semerari, Carcione, Dimaggio, Falcone, Nicolo, Procacci, & Alleva, 2003).

Our third and final argument for the importance of reconceptualization is our view that these narratives represent signs of a rupture or a discontinuity in the self. According to Zittoun (2007), identity ruptures are seen as subjectively perceived interruptions or

discontinuities in the normal sense of self that can lead a person to a questioning of one's own identity. This usually triggers a transition; that is, sense-making efforts that aim to restore continuity and integrity in the self while reducing uncertainty by creating an understanding of the rupture. This is, in our view, where reconceptualization IMs play an important part in the development of a new self-narrative: they function as communicational and semiotic devices that allow one to restore self-continuity. And this is carried out in a two-fold direction: both internally toward the person and externally toward others one engages in dialogue with. By bridging past, present and future through an understanding of what happened during the transition, reconceptualization links the old and the new self, what the person *WAS, IS* and *IS-NOT-YET*, making different self-experiences seem more consistent in a flowing narrative. Furthermore, in the context of psychotherapy, therapists can even enhance this process of meaning making in identity transitions, since therapists are specially attuned to the client's perceived self-changes and particularly interested in inquiring and fostering meaning about them. Reconceptualization IMs are usually felt as a positive, rewarding and motivating experience in psychotherapy, especially when they match the desired direction towards change (Santos & Gonçalves, 2009). Nevertheless, they can also possibly emerge from ambivalence and ambiguity, or even from intense inner-contradiction (Abbey & Valsiner, 2005; Valsiner, 2007). In these circumstances they also have the potential to become disquieting experiences.

Hence, we consider the emergence and evolution of reconceptualization IMs as interesting phenomena to study – not solely as an outcome (i.e. a marker for change) – but as the window to an organizing process in identity (Zittoun, 2006). We will address this issue through an intensive case-analysis.

2. SARAH: A CASE-STUDY

2.1. The client

Sarah (pseudonym) was a thirty-five year-old part-time college student, a German immigrant to Canada who participated in the York I Depression Study (Greenberg & Watson, 1998; Honos-Webb, Stiles & Greenberg, 2003). Sarah looked for therapy one

year after her divorce that ended 8 years of marriage with no children. In the first session, Sarah disclosed to her therapist that she wanted help to act upon her depressive feelings and increasing sense of isolation (see also Honos-Webb et al., 2003, for a prior publication that focuses on this case-study). At therapy intake, she presented some of the typical symptoms of depression, and these had lasted for several months. She was assigned to the Emotion Focused Therapy (EFT) modality and attended 18 sessions of psychotherapy. According to the improvement this client exhibited in the outcome measures used in this study (Greenberg & Watson, 1998; Honos-Webb et al., 2003), she was considered a successful case.

2.2. The therapist

Her therapist was a female clinical psychology doctoral student aged 33 years old, trained in client-centered therapy (for 3 years) and in emotion-focused therapy (for 1 year). She received additional 24 weeks of training for the referred study (cf. Greenberg & Watson, 1998; Honos-Webb et al., 2003).

2.3. Presenting problems

At the beginning of therapy, Sarah attributed her depressive symptoms to an increased social isolation and withdrawal. Further exploration of her difficulties in the first sessions of therapy uncovered three main intertwined problematic themes: 1) lack of assertiveness and self-boundaries in interpersonal relations; 2) feeling fused with and manipulated by the men in her intimate relationships; and 3) feelings of being neglected, ignored and undermined as a person by her parents (and especially her father). In her daily activities these problems became apparent in her difficulty to make personal decisions, sometimes procrastinating over important activities and becoming excessively reliant on the approval of others. Her tendency to frequently dismiss her own desires and needs in regards to others lead her to sense a very low confidence in discerning her own choices and preferences. On top of this, whenever she followed her own feelings and intuitions, she was frequently distressed by self-doubt and guilt, becoming afraid of losing other people's appreciation. At the same time, she felt her social life becoming more and more restricted with an increasing sense of loneliness and difficulty joining

new groups, along with social withdrawal. When talking specifically about significant romantic relationships (usually a former boyfriend and her ex-husband), Sarah usually talked about herself as the caretaker who freed these men from responsibilities, in order to let them develop their creative paths.

She linked the present difficulties with her social experiences growing up, both in school and with her family, emphasizing that she was always told to act politely and in consideration of other people's needs and suggestions, disregarding her own. Sarah talked about her family as her mother always attending to her father's needs – he was the sole economic provider for the family and a very strict, conservative man in his appreciation of the societal role of women. In Sarah's perspective, her parents consistently ignored her needs and opinions, and later on, her vocational interests in an art career. Even at the present moment, her father was not supportive of her choices: moving to Canada, divorcing her husband, pursuing art school (and not a more "feminine" professional field), always trying to dissuade her and encouraging her to come back to her country and settle down as a wife and mother. This, to Sarah, was like being undermined as a woman and invalidated as a resourceful individual.

2.4. Procedure

Although the therapeutic tasks addressed the several dimensions of Sarah's presenting problems, our analysis here will focus on the main problematic theme that is being dealt with in therapy: namely, lack of assertiveness and self-boundaries in current interpersonal relationships. Our decision to follow the development of the main theme was taken for two main reasons: 1) its extension in the therapeutic conversation (it consists of 77% of the transcripts) and 2) to increase clarity in this presentation, by selecting excerpts related to the same problem.

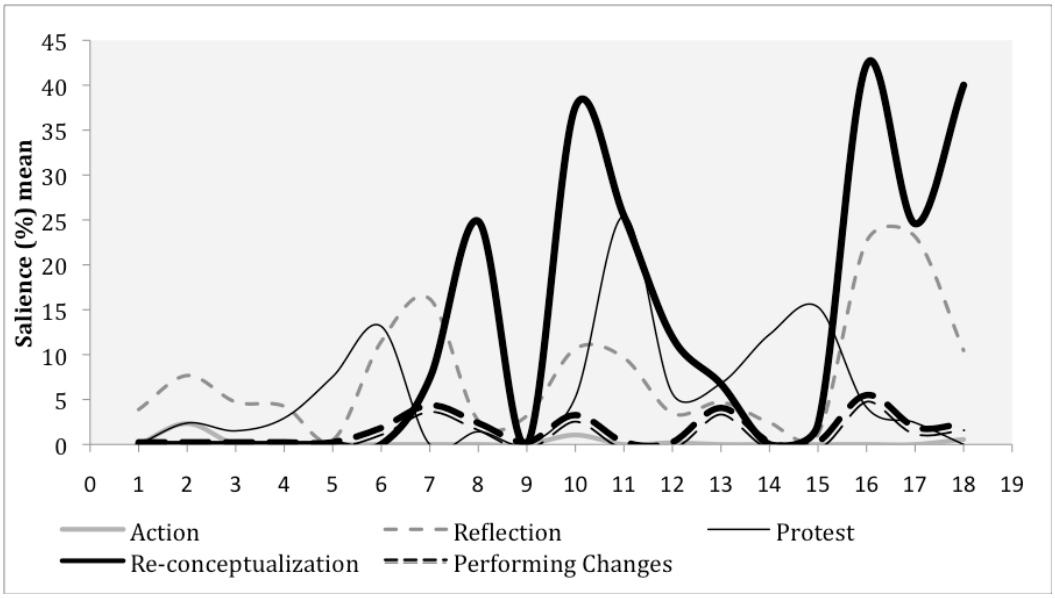
3. RESULTS

3.1. Development of IMs in the case of Sarah: A general overview

The therapeutic process of Sarah was coded for the presence of IMs and their textual salience (number of words occupied by the IMs, compared to the total number of

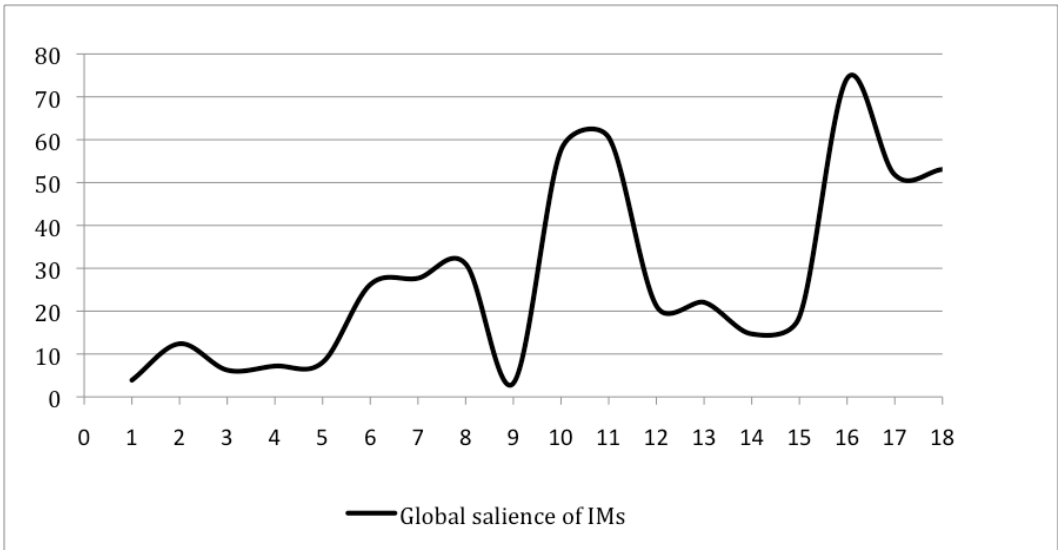
words in a session). Figure II.2 represents the distribution of the textual salience of IMs throughout the treatment. Several aspects are worth noting. First of all, the types of IMs that appear earliest are reflection and protest, which keep rising in their salience from session 1 to 8. From then on, an irregular pattern becomes visible concerning the textual salience of IMs and the diversity of types present (sometimes becoming more limited than in the sessions before).

Figure II. 2: Distribution of the salience of IMs over the course of Sarah's therapy



In a straightforward interpretation of the above graphic, we notice an increasing amplification in the diversity and textual salience of IMs until session 8, and also the emergence of a reconceptualization IM in session 7 (becoming the predominant IM in session 8 – we will focus on this excerpt below). However, in clear contrast to this movement, session 9 presents a noteworthy fall not only in the overall textual salience but also in the types of IMs exhibited. Afterwards, several periods of remarkable increase (referred as progressive) followed by yet other decreasing periods (referred as regressive) lead us to claim that the evolution of IMs in Sarah's case indicates several progressive and regressive lines in the evolution towards narrative innovation. Figure II. 3 represents these progressive and regressive lines more clearly, by displaying the global salience of IMs.

Figure II. 3: Overall progression of IMs' salience in the case of Sarah



We will now elaborate upon different excerpts of this case, trying to understand how reconceptualization IMs evolve and develop, reflecting the links with the progressive and regressive lines in the process.

3.2. Exploring the path to reconceptualization

Session 5 represents a major breakthrough in the therapeutic tasks, as Sarah agreed to perform the first empty-chair dialogue[6]. This happened as an attempt to work on lingering resentful feelings towards her father while performing an imaginary dialogue with him. This exercise can be considered a major instigator of the narrative changes she achieves in the following period, since it allowed her to understand and realize how her main difficulties (lack of assertiveness and social withdrawal) were related to a defensiveness towards others and an emotional blockage that were felt as needed while growing up in her family environment.

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6 Emotion Focused Therapy (or EFT) intends to facilitate the client's process of experiencing and exploration of core organismic needs, transforming maladaptive emotions into adaptive ones (Greenberg, 2004, 2006; Pos & Greenberg, 2007). This is accomplished by the integration of a client-centered relationship stance with more active interventions, derived from Gestalt therapy (e.g. Perls, Herline, & Goodman, 1951) and proposed after the detection of certain process markers. Some examples of such active techniques are the empty-chair and two-chair exercises. The first case is suited for the resolution of an unfinished business with a negative other, that the client imaginatively sits in the empty chair and talks to, trying to express the hurt that was caused by the other person. In the second case, the two-chair exercises are more suited for situations when there is a highly critical part in the self that restricts the will of a more fragile part or interrupts its wishes (as a self-critical split or a self-interruption process). The goal becomes to put the different parts in dialogue and arrive at a mutual understanding (Greenberg, Rice & Elliott, 1993).

Thus, in the following sessions, Sarah was more able to reflect about her problems and tried to act differently. This potentiates a qualitative change in Sarah's IMs exhibited by the emergence of the first reconceptualization in session 7. For example, in session 6 Sarah began by reporting to her therapist that she tried to celebrate the Christmas holidays differently: rather than being alone, withdrawn and depressive as was usual throughout the festivities, she decided to invite some acquaintances that were, like her, far away from home, and hosted a small gathering to celebrate with them. In the exploration of the meaning of this exceptional experience, Sarah described what could be considered as a plan of new intentions and self-instructions to follow in order to achieve practical and positive changes in her daily life. Her therapist, in turn, amplified the meaning making movement and motivation towards change that occurs in this session and this reinforces Sarah to achieve some concrete changes, which are reflected ahead. We will explore them as we focus now on the emergence of the first reconceptualization IM in session 7.

Sarah starts this session recognizing to her therapist that, even though some of the old difficulties are still present, some actual changes had been achieved during the week:

Excerpt 1: Session 7 – The first reconceptualization IM

Client (C): (…) [Reconceptualization IM, in italic, begins here] *before it would get to the point where I would get up and kind of do really basic things and then take a lot of breaks and rest during the day and that… kind of, not really disappeared, it's just simply because I'm so busy, I don't have the chance… And I guess the sudden – well it was kind of gradual, I suppose – but it leaves me pretty tired for things, but it's kind of a nice change of things.*

Therapist (T): *So it's hard to get started but once you're into it, it keeps you moving through the day.*

C: Yeah and I guess the thing really is that, if I'm on my own, I really let it go, let myself go, so I'm kind of trying to keep myself busy and involved, especially with other people. If I have to do something on my own at

home, it's just really difficult to get a move on things and… Well, I don't know, it's just how it works right now.

T: So it sounds like you're trying to give yourself some structure… You know you have to be at certain places at certain times…

C: Yeah, that kind of puts that certain amount of... pressure is maybe not the right word but just, I'm aware of what's going on and what is the best way to deal with it. (T: Mm-hm.) So, that really helps… and also I'm kind of getting the hang of it… Like what makes me uncomfortable when I'm with other people… (T: Mm-hm.) And really try my best, as soon as I notice it, to deal with it, to let them know that – no, this is not acceptable to me!, or – no, I can't deal with it for whatever reason but it's just too much and it works really well (laughs)

We notice here that the client reports more innovative actions happening during the week and begins to draw a contrast between her past usual functioning ("*before it would get to the point where I would get up and kind of do really basic things…"*) and her present functioning ("*so I'm kind of trying to keep myself busy and involved…"*). This is Sarah's first reconceptualization IM. In this IM, there is the acknowledgement of a self-discontinuity ("*it's kind of a nice change of things"*), although not the full acknowledgement of a rupture by the person (Zittoun, 2007), since Sarah still does not assume a complete identification with a new self-version, as evidenced by the instrumental nature of it. That is, at this point she has identified mere strategies to avoid feeling depressed (e.g. arranging commitments with others to be pushed to leave home and increase her level of activity). Nevertheless, this discontinuity starts building hope and positive feelings: "*a nice change of things"*.

The acknowledgement of this first self-discontinuity, however, emerges from an intense ambivalence intertwined all over the reconceptualization IM and after it. Several expressions illustrate quite well this ambivalence in the above example, like "*and that… kind of not really disappeared"*; "*it's just really difficult to get a move on things*." The therapist, attuned to Sarah, acknowledges these difficulties and tries to amplify and clarify the innovation achieved: note that she says "*it's hard to get started <u>but</u> once*

you're into it…" This movement directs Sarah towards the further exploration of innovation and is paralleled by the client in her following intervention, though finished with some hesitation ("*I don't know, it's how it works right now."*). The therapist, then, tries to amplify the recognition of these differences and how they are achieved, by eliciting an explicit elaboration upon what is different: more structure, increasing involvement. This intervention pushes Sarah to adopt a more abstract observer point of view towards her own reactions. She now recognizes her own attempts to become more familiar with this novel way of functioning ("*I'm getting the hang of it"*), reaffirming the need to become self-assertive ("*really try my best… this is not acceptable to me!"*) and reinforcing the positive feelings that accompany this new attitude. The therapist extends this movement of consolidation of novelty by paraphrasing and nominating the two things that *are* different – so that Sarah now adopts a more definitive appreciation of the changes. And Sarah also now recalls her values, goals and desires ("*really try my best, as soon as I notice it, to deal with it"*), renewing her motivation to keep changing ("*it works really well"*).

But at this point ambivalence re-appears in the conversation:

Excerpt 2: Session 7 – The first reconceptualization IM and after

C: [Reconceptualization IM continued from excerpt 1] *Even though it creates, at the time (some anxiety)… And then I think – okay, right now this is it. I have to do or say something, otherwise it's going to happen again and people are going to start wondering like what my problem is or, you know… So, I get kind of tense about it but then I say or do whatever it is and like, it's just… I can't believe how difficult I find it, to do this, to be assertive (T: Hmm.) about things…* [Reconceptualization IM, in italic]

T: So it feels like it shouldn't be so difficult.

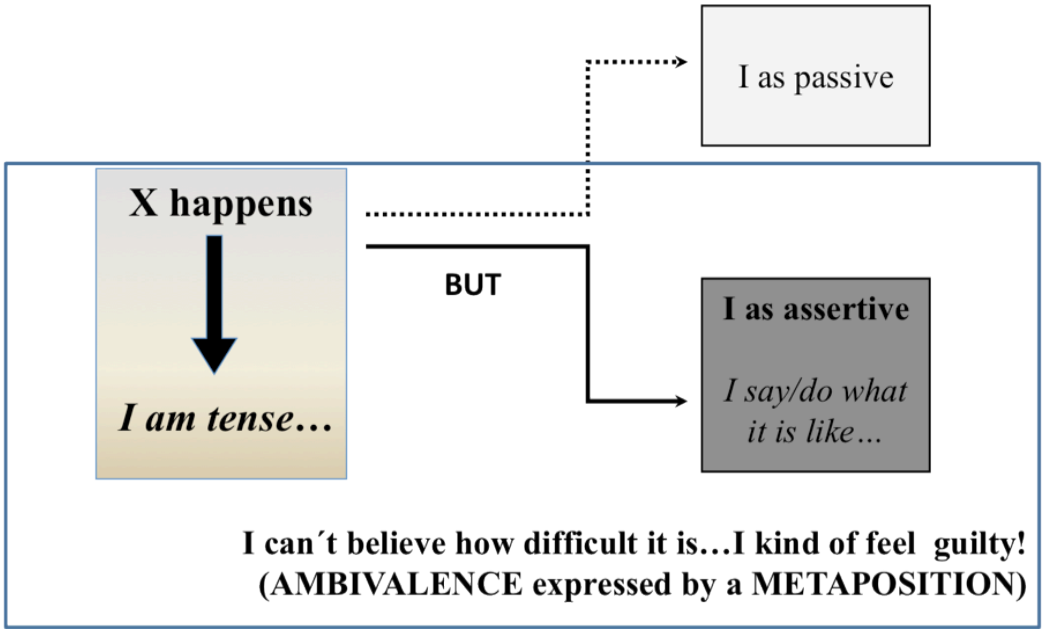
C: Yeah because I feel kind of guilty about it. [that is, to be assertive] (T: Hmm-hmm.) For somewhere around a day almost, you know, like *I was entitled really to do this. (T: Hmm-hmm.) You know, such as – did I, did I hurt the other person? It's always like I'm more concerned about*

> *what I do to the other person than saying – well, this is me, I have to look at myself first, other people are doing it and I have to let them know where the limit is, that they do have to look for a different approach or that they definitely overstepped it.* [Protest IM, in italic]

In this part of the conversation, Sarah starts to implicitly recognize the difficulties she had been feeling in regard to change ("*even though it creates, at the time"*). The therapist captures how poignant Sarah's ambivalence is, and acknowledges it, reflecting it towards her ("*it feels like it shouldn't be so difficult"*). Sarah appears here still very much engaged in her usual way of relating to others, labeling her discomfort feelings as *guiltiness* about self-empowerment. However, as soon as she expresses her guilt feelings, she immediately repositions herself in a more assertive way – as entitled – and dissuades her doubts ("*I have to look at myself first"*). These difficulties in being spontaneously assertive were immediately circumvented ("*right now, this is it"* –Josephs & Valsiner, 1998, call these discursive devices as circumvention strategies), interrupting her self-doubts and directing her, again, to self-assertion: "*I have to do or say something"*. The reestablishment of the movement towards change was also accomplished by another circumvention strategy that relied on an adversative conjunction ("*I get kind of tense about it <u>but</u> then I say or do whatever"*). In this process, she is progressively and gradually distancing herself from the problematic self-narrative, reinforcing an innovative alternative: a protest IM appears.

As we can see, this step forward towards self-assertion, that prompts innovation in the form of a protest IM, is achieved after a recursive movement – in a step back into her old self – when she elaborates on her difficulties and ambivalence in pursuing her desired changes: "*I can't believe how difficult I find it…"* Her ambivalence can be illustrated as follows (figure II.4).

Figure II. 4: Ambivalence in Sarah's first reconceptualization IM



In this first reconceptualization, even though there is a contrast between present (self-assertion) and past (passivity), there isn't yet a clear identification with a new self-narrative. This ambivalence is related to an oscillation between the old self-version and the new (yet not totally integrated) self-version. In our view, this excerpt illustrates – not a complete return to the problem – as it happens in mutual in-feeding –, but a recursive process that seems needed to boost and maintain the directionality towards change. Thus, we see the client moving – gradually – towards a distancing (or disengagement) from the problematic position and getting closer to a new self-assertive position. In other words, Sarah is not identifying herself anymore with the problematic narrative in this moment of the therapeutic process, but the identification with a new self-narrative (e.g. self-assertive) is not yet complete. In this sense, the ambivalence is not between problem and innovation (*I am insecure* vs. *I should be assertive*, as in the case of mutual in-feeding) but between innovation and the meta-reflection upon it: *I was able to be assertive* [innovative voice in the experiencing self] vs. "*I can't believe how difficult it is!*" [metaposition]. Nevertheless, although there is ambivalence felt at the level of the metaposition, the client does not seem to jeopardize her motivation towards change.

The emergent self-assertive position, since it is still new and unfamiliar, requires self-reflexivity and a lot of conscious effort in adopting a new behavioral attitude. Here, then, is a moment of highly noticeable inner-dialogicality. The expression of this ambivalence towards an accepting other (the therapist) seems also productive in order for Sarah to elaborate further her motivation to change – entailing a back and forth movement. Thus, the ambivalence that appears in this reconceptualization IM is then progressively dissolved in the therapeutic conversation as Sarah moves herself, more and more, to an identification with a new self-version, while being empathically understood by a therapist that is attuned to the difficulties implied by this transitional process. Thus, as soon as she revisits the past, she can then embrace more fully the future, in her present transitional journey.

This first reconceptualization IM and the following dialogue around it is, for us, an example of an important *scaffolding* process of development (Valsiner, 2005) that happens in the context of a socially constructed *zone of proximal development* (ZPD –a concept by Vygotsky, 1978, cited by Leiman & Stiles, 2001) towards change and innovation. The concept of ZPD derived from Vygotsky (1978), when applied to the field of psychotherapy, can be referred to the therapist's actions that globally aim to promote the client's development (cf. Leiman & Stiles, 2001; E. Ribeiro, 2009). In the dialogue that we analyzed from the excerpts above, it was actually the acknowledgment of the difficulties and the validation of Sarah's perspective (reaching the client at the level where she was) that we see as key in the resolution of this ambivalence and the reinforcement of the directionality towards change

3.3. The consolidation of reconceptualization: Working-through in the metaposition

We turn now to a reconceptualization that appears in session 10, trying to elaborate upon the evolution between reconceptualization IMs along the therapeutic process. We will focus essentially on how reconceptualization develops within the conversation and how it relates to Sarah's experience, contrasting this moment with the first reconceptualization that we analyzed previously. Sarah begins this session by reporting to her therapist that she has been committed to experiment with a more open social attitude, trying to connect with

others. In turn, this more open attitude has generated some interesting and surprising experiences.

Excerpt 3: Session 10

C: (…) *these barriers I mean, they are still there to a certain extent but it just seems to be much easier all of a sudden just talking to people, and with people I have known for sometime as well. I guess it depends on everybody including myself, like waiting at a bus stop or at a grocery store, it's just like: Let's see, you know, can I do this?* [Reflection IM, in italic, ends here] (T: Hmm.) And most of the time it's like people just want to talk, you know.

T: Yeah, you realize it works. […]

T: So people really respond and you're able to get things moving and make changes. (C: Yeah.) Almost like, one thing leads to another, kind of.

C: Yeah. And it definitely gives me, I don't know if I really want to call it a sense of control, [Reconceptualization IM, in italic, begins] *but it's like, with opening up, it creates more possibilities… And naturally – yes, there are still going to be times where people are going to say no and not respond to it – but it doesn't take me from the chances of meeting or running into people (…) whereas before I just wouldn't do anything and just limit myself severely.*

T: I think you're saying that before the risk that someone might not respond to you used to stop you from trying.[Therapist recapitulates the problematic voice, using indirect speech] *(C: Yeah, yeah.) And somehow now you say: Okay, maybe they won't respond but some will, and go with the positive.* [Therapist recapitulates the innovative voice, using active speech]

C: Yeah, yeah, yeah. Oh yeah, even though it's sometimes hard, I guess I like to talk to people and hear the no three times and then maybe at the fourth or fifth time you get finally a yes or they have the answer or a solution to it, but I just keep telling myself that it really helps.

T: So you tell yourself what… Keep persisting or just don't give up hope?

C: Yeah and don't feel bad about it. Like it doesn't have anything to do with myself, it's just whatever their circumstances are, they don't have the resources or something prevents them. They just can't, they probably want to but just leave it and don't try to force. I guess the major thing is also not trying to figure out all the reasons for it. (T: mm-hm.) Just: Okay the if, when, but… - who cares about it?!

T: That's okay.

C: Yeah, that's okay, exactly. Yeah.

T: It sounds like a very important sort of way, a ***new*** *step or something, that you don't take it on yourself or start feeling like: Oh, what did I do wrong? They don't like me! It's more like: Well, those were their circumstances and who knows about them?*

C: Exactly and then at the same time, I guess one of the things in the past is that I just really catered too much for other people and now when something comes up it's like: Do I really want to, do I really feel like it, does it really suit me? And also if it doesn't, then it is a no and that's it.

T: So there's sort of a ***new*** *stage where you might accommodate other people but you first stop and check out if that's really what you want to do?*

C: Yeah, if it really is okay with me, if it really suits me, yeah. [Reconceptualization IM continues further in the session]

In this case, we notice that the client starts by revisiting the past: her prior self-narrative in a reflection IM, but then immediately disengages herself from it through a circumvention strategy and emphasizes how easy it is now to behave differently ("*these barriers they are still there to a certain extent but it just seems to be much easier all of a sudden just talking to people"*). The therapist reinforces this movement towards innovation, trying to amplify the elaboration upon what has changed ("*you realize it works"*). This amplification is successful, since it triggers more elaboration and reflection

at the level of the metaposition of the client, prompting a reconceptualization IM. At this point, Sarah has already identified herself with the new assertive self-position (in contrast with the first reconceptualization IM in session 7), and actively tries to establish the continuity through the self-rupture, integrating the contrast between past and present: "*yes there are still going to be times where people are going to say no and not respond to it* [past non-assertive self] *but it doesn't take me from the chances of meeting or running into people"* [present changed self]. Actually, this connection is what Brinegar, Salvi, Stiles and Greenberg (2006) call a meaning bridge. A meaning bridge expresses an understanding between opposites (e.g. contrasting affective experiences, opposing perspectives between self and other or between parts of oneself) and is considered a powerful semiotic tool to achieve self-integration and reconciliation in therapy (Brinegar et al., 2006).

We also note here again the important meaning making movement of recapitulating the past as a way to increase the contrast with the present and thereby, amplify it. This is what Sarah does during the reconceptualization IM and this contrast is again paralleled and expanded by the therapist as she interprets Sarah's experiences. More specifically, the therapist uses here several strategies that help in the effort to consolidate novelty.

First, the therapist voices the problematic and innovative positions in several turns, shifting from the problematic voice to the innovative voice: "*you're saying that before the risk that someone might not respond to you used to stop you from trying.* [Therapist referring to the problematic position in passive speech] *And somehow now you say: Okay, maybe they won't respond but some will,* and *go with the positive."* [Therapist recapitulates the innovative position through active speech]. Second, the therapist introduces and calls upon higher order values – persistence and hope – linking them to change, the therapist also strengthens Sarah's efforts, framing current difficulties as opportunities and not anymore as obstacles to change. Third, as the therapist persists, dismissing the importance in the possibility of others' not responding to Sarah's attempts to increase social contact and become assertive, she adopts a repeated labeling process that pinpoints these events (i.e. "*new"*) and several metaphors that qualify them ("*a new step"; "sort of a new stage").*

As Sarah agrees with her therapist, recapitulating the difficulties ("*even so it's sometimes hard…"*) and circumventing them ("*but I just keep telling myself that it really helps"*), the end result is the persistence in the elaboration around innovation. We consider the use of these circumvention strategies important here for the maintenance of the directionality and persistence towards change. This also helps to potentiate the work at the level of the client's metaposition, since Sarah recognizes that she is no longer wholly interested in accommodating other people and is now more focused on her own needs ("*if it suits me, yeah"*).

In the two reconceptualization IMs selected here (the first one from session 7 and another from session 10), we see how the client is faced with the need to recapitulate the past as a way to increase the contrast with the present, thereby allowing a meaning bridge that unites past and present self-narratives. This integration, accomplished through these therapeutic strategies and semiotic tools (like the establishment of meaning bridges) and through a mutual coordination in meaning making efforts around the elaboration and understanding of changes carried out by client and therapist, seem to be a crucial aspect in the innovation, rehearsal and development of a new identity.

3.4. Rethinking who I am: Sarah' self-doubts return

Until now, reconceptualization IMs are present consistently in relation to the main problematic theme since their emergence in session 7 (they frequently appeared several times within a single session). Session 9 is an exception to this path but somehow seems to preview the regressive line that develops from sessions 12 to 15 (see figure 2). This regressive line starts appearing mildly in session 12, associated to some negative events that happened to Sarah during the week, which were a topic for reflection in the therapeutic conversation. During both session 12 and 13, although Sarah is still capable of exploring meaning making in innovative fields, IMs are much more circumscribed than in earlier sessions (their textual salience drops by a half). In session 13, Sarah even begins by reporting to her therapist how she has been alternating between positive and negative periods. During these two sessions, several self-split empty-chair experiential exercises were conducted with the aim of addressing her inner ambivalence between assertiveness and self-doubts. This emotional exploration and reflection seems to be powerful enough to

trigger reconceptualization IMs. Nevertheless, it is in sessions 14 and 15 that Sarah gives a wider expression to her ambivalent feelings and starts doubting the meaning of the changes appreciated up until then. In these two sessions, reconceptualization and performing change IMs do not appear at all (until the very end of session 15) and all IMs are materialized in the form of protest and reflection, similar to the phase prior to reconceptualization (i.e., before sessions 6 and 7). We will focus now on a specific excerpt from this period.

In session 15, Sarah begins by telling that she is feeling a bit negative but is not fully aware of the reasons why, partly because she tries not to think about it too much. During the session, her therapist tries to engage her in emotional exploration and self-reflection as a way to explore Sarah's feelings (a strategy called focusing in EFT – Greenberg et al., 1993). Sarah starts explaining how she has been trying to find a job more suited to her artistic interests and how she feels distressed and angry when other people do not support her wishes. Sarah and her therapist then explore how this anger is felt as not being recognized or validated by others, which in turn triggers Sarah's self-doubts about her own desires. Noting this self-conflict, her therapist proposes a dialogue with her inner critical part, where Sarah explores how her inner-criticisms frequently inhibit her to struggle for her own goals and pursue what she believes. Afterwards, Sarah and her therapist reflect upon the experiential exercise:

Excerpt 4: Session 15

T: But it seems like there's this really strong message whether it's from your father or from other people or something that you partly get and in your own mind as well because of your upbringing... All these messages of how you should be and sort of this thing about wanting too much for yourself... I mean, I guess where we got into today is what happens when you hear those things... Is that you just sort of give up? You feel overwhelmed and you can't do any of those things?

C: Yeah, yeah... Well, I just thought that people really actually told me, to my face, that I'm never satisfied and with my mood swings, that I'm difficult... Well, that's not their words, but I'm saying that I'm difficult to control, but who wants to be controlled? *And that just makes me*

furious, you know, because you don't have to tell me this, like this is your problem, like this is the way I am and don't you tell me you are in a good mood all the time, you know... And if I'm not in a good mood and you can't cope with it, I don't expect you to talk to me or spend time with me, you know [Protest IM, in italic, ends here]

T: You see, I think there's part of you that gets furious and says that's not true and I'm not like that, and there's another part that sort of buys the party line.

C: Oh yeah.

T: And I think that is maybe the struggle... (C: Yeah, yeah.) And at times when you feel the energy and to hell with them, you're up and doing stuff. Then at other times, it's like maybe they're right, maybe I can't or...

C: Oh yes, oh, yes, absolutely. **[**Reflection IM, in italic, mainly elaborated by the therapist, ends here**]** **(**T: yeah) Yeah, because I mean again that happened. Well, there was a time when two or three people, within a very short period of time told me all these things and it's just like "It must be true" (laughs) and it's just really difficult then to say **"**Oh, to hell with it, you know, I'm going to continue or do whatever I want to do"

T: It is difficult and we all have our own self-doubts and we want encouragement and when other people tell us one thing, we start to question ourselves... It sounds like you've been told from very young what your limits are and what they should be and it's hard to believe that you could – as a little child – say: I won't listen or I won't let it sink in...

C: Yeah, yeah, for sure **[**Reflection IM, in italic, mainly elaborated by the therapist, ends here**]**

T: Those things maybe did to some extent sink in and almost get re-activated when you hear things like that from other people or you sense things like that from other people.

C: Yeah, for sure, because I just don't know how to cope with it, I just can't generate this energy to overcome all these hurdles.

T: I think what we've started doing in the last few weeks and today and what we need to continue doing is really get a sense of what those messages are that get to you. (...) Even if we haven't solved how to get past them, it's very important to recognize what's happening at those times when you... you know, you said so clearly: I just have no energy to even turn on the computer, I just feel so drained and so hopeless and so...

C: Yeah. I have all these doubts about myself and about other people, so when people actually say and do certain things, I don't even realize at the time what triggers it... (T: Hmm-hm.) *I mean it has gotten better... In the past I didn't notice it at all, because it was just so engrained, but at least now, probably not all the time, but I feel that really a lot of times when things like that happen that I notice it. And even so maybe at the time I agree with the person and say: well, yeah, maybe I should do this... I don't find it too difficult to get back to them and say: By the way, no! And this is something that is really good because I don't feel too bad that I wasn't able to respond to it right away, I'm still able to make a point of getting back to them and almost like correcting the situation. (T: Hmm-hm.) And I just have to keep on working on this* (laughs) [Reconceptualization IM]

In this excerpt, we see a very active therapist, summarizing what was understood in the session and challenging the client to develop her insight about her present difficulties. The therapist begins by explicitly linking Sarah's internalization of negative messages from others while she was growing up, with her present self-doubts and lack of confidence. Her emphasis at this time appears to be on the promotion of insight through the exploration of her experience during the problematic event and working at the level of the metaposition ("*All these messages of how you should be and about not wanting too much for yourself... You feel overwhelmed…"*). This fosters the emergence of a protest

IM that seems to be important for reinstating again the directionality towards self-assertion: at this moment Sarah recognizes the injustice of not being validated and how her past still impacts the present. In the following turns, the therapist continues to expand reflection at the level of a metaposition, through a reflection IM that is mainly elaborated by the therapist. Afterwards, the therapist also frames the client's current difficulties and ambivalence towards change as something expected and understandable when taking into account her experiences while growing up ("*It sounds like you've been told from very young what your limits are and (…) it's hard to believe that you could – as a little child – say I won't listen or I won't let it sink in…"*)

This leads Sarah to a recognition of her difficulties and lack of resources to overcome this barrier – in a full return to the problem ("*I don't know how to cope with it because I just can't generate this energy to overcome that"*). In her turn, her therapist reinforces the emphasis in the direction of change by recapitulating their prior efforts, disconfirming Sarah's sense of incompetence and reaffirming the need to keep working on these issues, pushing towards innovation and change as something on the way. She demonstrates this with concrete examples of the past, assuming her client's voice to increase persuasion and accentuating what still needs to be done without complying with Sarah's discouragement.

We consider that these interventions from Sarah's therapist can be again considered as attempts to foster development within the ZPD – note how the therapist validates Sarah's struggles and negative experiences but frames them in a positive way. The therapist aims to build hope by redirecting Sarah to keep her motivation to change when she emphasizes what has been already achieved and presenting difficulties as something to be expected and still to be worked upon, without discouragement. And this emphasis seems to be successful since Sarah picks up on this contrast towards the past, initiating a reconceptualization IM: "*It has gotten better... In the past I didn't notice it at all, because it was just so engrained, <u>but at least now</u>,* [circumvention strategy to diminish the importance of the past] *probably not all the time* [remnants of the old self-narrative]*, <u>but I feel that really a lot of times</u>* [another circumvention strategy to devalue the past] *when things like that happen that I notice it"* [affirms present achievements]. This excerpt demonstrates that the process of Sarah's disengagement with the prior self-narrative and

problematic position and identification with an innovative voice, where a changed self-narrative is being consolidated, as the conversation flows in this session: "*And this is something which is really good* [emphasis on the present innovative position and positive feelings associated to self-assertion] *because I don't feel too bad that I wasn't able to respond* [contrast with the old self-narrative] *(...) I'm still able to make a point of getting back to them and almost like correcting the situation"* [identification with a present self-assertive position]. Another example of the disengagement from the problematic position and an identification with the innovative position being rehearsed, could be: *"And even so maybe at the time I agree with the person and say: well, yeah, maybe I should do this*...[Problematic self-position being recapitulated] *I don't find it too difficult to get back to them and say: By the way, no!"* [Identification with the innovative self-position].

Sarah finalizes this reconceptualization IM with an important assumption that directs her motivation to persist and persevere in the path of change ("*And I just have to keep on working on this"*). The contrast that Sarah is able to make here between her past reaction towards the negative messages of others and the present doubt that she places on these messages reinstates a definite progressive line until the end of therapy.

4. DISCUSSION: WHAT CAN WE LEARN FROM SARAH?

This specific case study allowed us to observe some interesting processes taking place in the therapeutic encounter. It also offers several challenges for our theoretical understanding of the evolution of IMs. We will now try to integrate and synthesize the multiple observations that this case study originated.

4.1. Change is not a linear process, even after reconceptualization

We began this study with the notion that reconceptualization IMs have the ability to potentiate and amplify the construction of other IMs. Prior case studies had established that, when reconceptualization emerges, not only do we notice an increase in the overall salience of IMs, but also – and most importantly – there is an expansion of meaning making towards innovation that potentiates the disengagement from a previously dominant self-narrative. Thus, the notion of a progressive tendency in the construction of

IMs had already been observed in prior case studies, emphasizing what usually happens after reconceptualization (Santos & Gonçalves, 2009).

However, in Sarah's case, we are also faced with regressive movements after the appearance of reconceptualization IMs. Actually, on more than one occasion there was a decrease in the presence and diversity of IMs, as these regressive lines appear alternating with other progressive lines in the construction of novelty. This finding suggests that some clients may need to deal with the problem *through a recycling* of previous stages in therapy progression, as well as to deal with setbacks (e.g. negative life events) that can occur during the course of therapy (Brinegar et al., 2006). In Sarah's case, we noticed that several negative events appeared in her daily life during the treatment and these were frequently the object of the therapeutic conversation.

Of course, this irregular pattern can also be associated with a multifaceted problem. We believe this is consistent with Sarah's case since her problematic narrative was related to several problematic themes in the beginning of therapy and we consider that not all of them were fully dealt with in this process7.

4.2. The role of recursivity in the consolidation of change

The succession of reconceptualization IMs seen here resembles more a spiral process of meaning making rather than a revolutionary process, in which the new suddenly substitutes de old patterns. Instead of a radical change, the evolution of reconceptualization IMs in Sarah's case proceeds within a back-and-forth, recursive movement. Not only does this process evidence a revisiting of the past but also shows that every time the past is revisited, it is more easily integrated in the present, accompanied by a fading-away of distress and uncertainty. More specifically, a movement backward may be needed, on the one hand, to boost and amplify meaning making in the innovative field, and on the other, to rehearse meaning bridges between the problematic past and the more promising present and future. These meaning bridges need to be constructed and rehearsed several times, before they can be fully consolidated and

[7]These findings are also congruent with the sawtoothed pattern identified before by Brinegar et al. (2006) and characterized by several shifts in the progression towards the assimilation of problematic voices in an emotion-focused therapy case.

carry out the integration of past experiences as personal resources in a new self-narrative (Brinegar et al., 2006).

Thus, recursivity and circularity do not need to be considered negatively – they can be precisely the necessary ingredients for the rehearsal of a new identity.

4.3. The transition to reconceptualization can be highly ambivalent

We can conceive the construction and growth of a new self-narrative as departing from this unit of analysis: *rupture – irruption of uncertainty – transition* (Zittoun, 2007). Hence, reconceptualization IMs seem to emerge precisely from these experiences of rupture and uncertainty and can be thought of as a particular way of meaning making derived from perceived ruptures in the self. Although we assumed that the notion of rupture is already implied at the core of the definition of a reconceptualization IM (given that the person has to contrast the self in the past and the self in the present), Sarah's case-study illustrates how distressing and extensively ambivalent this transition can be, even though it is in the direction of a desired state that is aimed by the client.

The selection and analysis of several moments of emergence of reconceptualization IMs was carried out precisely to understand further the work of a transitional process in the development of a new self-narrative. Sarah's case – because it was so ambivalent – slowed down this transition enough to allow the observation of the initial uncertainty and the fading-away of these distressing feelings in the evolution of subsequent reconceptualization IMs, as they were being consolidated and validated within and outside therapy. We consider that the uncertainty and ambivalence signaled in this process derived from an initial disengagement of Sarah from her formerly dominant self-narrative, combined with the not yet achieved re-identification with a new self-narrative. We claim that until this re-identification is not carried out, the person can experience deep puzzlement, and will have trouble understanding who she is in the present, now that she is not the same person she was in the past. Sarah's case also shows that the reestablishment of a missing self-continuity through the identification with a changed self-narrative can be a tentative process, where the need to revisit the past and reconnect it to the present may require several rounds before it is fully consolidated and the person feels a new familiarity with it.

4.4. The development of a new self-narrative requires distancing and a metaposition

If there is such high distress involved in the emergence of these key IMs, we should ask: how come reconceptualization and subsequent IMs evolve further to a strengthened identification with a new self-narrative, instead of Sarah retreating into the old one? Changes are needed to maintain a certain kind of adjustment to the environment, but it doesn't mean that all changes are developmental (Zittoun, 2007). The paradox of mutual in-feeding is, to us, one example of non-developmental change: the person is flopping, or changing from position X to opposing position non-X, immediately getting back to the initial place. This repetitive process prevents further (qualitative) changes and undermines the creativity of personal agency by keeping the person in the same state of affairs.

We argue that the development of a new self-narrative and a new way to conceive ourselves implies not only narrative changes, but also psychological development. The notion of development, however, originates from a teleological orientation. A developmental change, thus, is one that fosters further changes, allowing the agent to become more creative and flexible, and more easily able to adjust to the surrounding environment in the next future (Zittoun, 2006, 2007). So, it is this kind of change that we are aiming at when we are talking about the development of a new self-narrative and the role that reconceptualization plays in it.

We believe that psychological development happens in Sarah's case because the ambivalence seen in some reconceptualization IMs involves different levels of generalization of meaning. The ambivalence it is not occurring between the same level of the meaning making process as it occurs in the mutual in-feeding process (Valsiner, 2002), like in two opposing voices (*I want be happy* vs. *I feel miserably*), but between the experience in the self and a metaposition of it. More specifically, Sarah was distancing herself from her problematic experience (acting in a changed way) and commenting and reflecting about it as she developed this metaposition, observing herself in the situation. In other words, Sarah's ambivalence is not typically between two conflicting alternatives within the same level of experience (namely, uncertainty about being passive or

assertive), like in a typical mutual in-feeding process. Instead, the ambivalence that we have noticed was between the metaposition and the experiencing self – in other words, it is an inter-level ambivalence. Furthermore, we hypothesize here that this type of ambivalence can be potentially creative and developmental, while same-level ambivalence is not, since it leads only to redundant changes and not to developmental ones. We have hypothesized additionally that it is this meta-level, self-observing feature of reconceptualization IMs that gives the potential to make them developmental, while other types of IMs do not provide this.

5. CONCLUSION

Human development is an indeterminate, creative, sometimes recursive process of present enablement combined with a constraining of future possibilities, while continuously establishing bridges within personal history. We have argued here that human development as it is observed in psychotherapy, needs the recursive movement of revisiting the past to boost the construction of present meaning making directed to the future. In this domain, the process can be described as a spiral path towards psychotherapeutic changes – where evolution implies a succession of progressive and regressive movements that allow a consolidation of further transformations. In the case of reconceptualization IMs, the act of revisiting the past with the purpose of integrating it in a narration of the present seems to be a vital process for the reinstatement of a new self-continuity and the creation of a new self-narrative after a perceived rupture due to the disengagement with a former self-narrative. Moreover, the meta-reflective process implied and achieved by these narratives seems to be the result of conjoint therapeutic efforts in the dyad, particularly the therapist's induction of movement towards the expansion of meanings within the zone of proximal development of the client. In this sense, the therapeutic interaction seems to be a beautifully coordinated and improvised dance between client and therapist, where each responds to the others cues and creatively engenders next moves and possibilities in meaning making.

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CHAPTER III

TRANSFORMING SELF-NARRATIVES IN PSYCHOTHERAPY: LOOKING AT DIFFERENT FORMS OF AMBIVALENCE IN THE CHANGE PROCESS

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TRANSFORMING SELF-NARRATIVES IN PSYCHOTHERAPY: LOOKING AT DIFFERENT FORMS OF AMBIVALENCE IN THE CHANGE PROCESS[8]

1. INTRODUCTION TO STUDY 3

In recent decades, several psychologists have emphasized the central role that narratives play in human life (Bruner, 1990; Hermans and Hermans-Jansen, 1995; McAdams, 1993; Sarbin, 1986). If, as Bakthin (1984) argued, 'to be is to communicate' (p. 187), narratives are as important to the self as they are for others with whom we relate: one (re)constructs and (re)presents oneself through narrating, being influenced by the dialogical parties we encounter in life. Therefore, a fundamental challenge for psychological science is to find out how the self is constituted and transformed through narratives. Namely, what kinds of narratives empower the self with adaptive resources fostering self-development, and what other kinds block transformation, increasing vulnerability?

According to narrative and dialogical perspectives, some self-narratives may become dysfunctional and constrain personal adaptation if they lack differentiation, flexibility or become too redundant. For example, some self-narratives may express a dominant voice (or a coalition of voices) that silences alternatives (Hermans and Kempen, 1993) or become so saturated on problems that the disempowered self surrenders in helplessness (White and Epston, 1990). Other self-narratives may show a redundancy of themes or contents around hurtful experiences and characters (Hermans and Hermans-Jansen, 1995), indicating a bias towards negative events on autobiographical recall and perpetuating a negative view upon oneself (Gonçalves and Machado, 1999). Other narratives may be too disorganized and unspecific, failing to articulate a coherent sense of personal agency (Boritz et al., 2008; Botella et al., 2004). These examples illustrate some of the features that frequently characterize problematic

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[8] A version of this chapter appears as Cunha, C., Gonçalves, M. M., & Valsiner, J. (2011). Transforming self-narratives in psychotherapy: Looking at different forms of ambivalence in the change process. In R. Jones & M. Morioka (Eds.), Jungian and Dialogical Self Perspectives (pp. 43-66). Basingstoke, UK: Palgrave Macmillan.
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narratives exhibited by clients in the beginning of psychotherapy, leading them to seek professional help (see Dimaggio, 2003, for a comprehensive discussion).

Our research program has tried to depict how the elaboration of novelties allows the transformation of problematic self-narratives in the psychotherapy context (Gonçalves, Matos and Santos, 2009; Gonçalves et al., 2010). For that we created the Innovative Moments Coding System (Gonçalves, Ribeiro, Matos et al., in press) that allows tracking novelties that emerge in the therapeutic conversation. If we consider the problematic narrative presented by a client as a rule, these novelties are all the experiences that are taken as exceptions that contradict it. We call these experiences *innovative moments* (hereafter IMs; Gonçalves, Santos et al., 2010) to refer to the actions, feelings, intentions and thoughts that express defiance towards the dominance of the problematic narrative. This is inspired by White and Epston's (1990) notion of 'unique outcomes', i.e., experiences outside the influence of the problem-saturated stories that clients bring to therapy.

To summarize this chapter's main assumptions – and adopting the theater analogy, useful in the dialogical self perspective (Hermans, 2001; Hermans, Kempen and Van Loon, 1992) – we can conceive the problematic self-narrative as the expression of a voice or coalition of voices that monopolizes the floor of the dialogical self and restrains the expression of alternative voices. Consequently, the problematic voice(s) assume the narrator's position, controlling which self-narratives become possible to express, without relenting its power to non-dominant voices. In contrast, IMs represent the narrative expression of alternative voices that in time take the floor, being heard and developed in psychotherapy, and contest the dominant voices that saturate problematic self-narratives. Every time a meaningful change is noticed in the therapeutic dialogue, alternative voices (new or previously dominated) can come to the foreground and start to develop potential new narrators and more flexible self-narratives.

Below, we elaborate on different instances of ambivalence between problematic and innovative voices manifested by clients during the change process. We also discuss the potential of developing and expanding the activity of a metaposition in the self as a way to deal with ambivalence and to strengthen the path towards a new self-narrative.

1.1. Narrative change in psychotherapy: Elaborating the role of innovative moments

The Innovative Moments Coding System distinguishes five types of IMs: action, reflection, protest, reconceptualization and performing change IMs (see Table III.1).

Table III.1: Types of Innovative Moments with examples from depression

Types of Innovative Moments	**Examples** (Problematic narrative: depression)
ACTION IMS	
Action IMs refer to events or episodes when the person acted in a way that is contrary to the problematic self-narrative.	*C: Yesterday, I went to the cinema for the first time in months!*
REFLECTION IMS	
Reflection IMs refer to new understandings or thoughts that undermine the dominance of the problematic self-narrative. They can involve a cognitive challenge to the problem or cultural norms and practices that sustain it or new insights and understandings about the problem or problem supporters. These IMs frequently can also assume the form of new perspectives or insights upon the self while relating to the problem, which contradict the problematic self-narrative.	*C: I realize that what I was doing was just, not humanly possible because I was pushing myself and I never allowed myself any free time, uh, to myself … and it's more natural and more healthy to let some of these extra activities go…*
PROTEST IMS	
Protest IMs involve moments of critique, confrontation or antagonism towards the problem and its specifications and implications or people that support it. They can be directed at others or at the self. Oppositions of this sort can either take the form of actions (achieved or planned), thoughts or emotions, but necessarily imply an active form of resistance, repositioning the client in a more proactive confrontation to the problem (which does not happen in the previous action and reflection IMs). Thus, this type of IMs entails two positions in the self: one that supports the problematic self-narrative and another that challenges it. These IMs are coded when the second position acquires more power than the first.	*C: I am an adult and I am responsible for my life, and, and, I want to acknowledge these feelings and I´m going to let them out! I want to experience life, I want to grow and it feels good to be in charge of my own life. I am not going to put up with this anymore!*
RECONCEPTUALIZATION IMS	
Reconceptualization IMs always involve two dimensions: a) a description of the shift between two positions (past and present) and b) the transformation process that underlies this shift. In this type of IMs there is the recognition of a contrast between the past and the present in terms of change, and also the ability to describe the processes that lead to that transformation. In other words, not only is the client capable of noticing something new, but also capable of recognizing oneself as different when compared to the past due to a transformation process that happened in between.	*C: You know… when I was there at the museum, I thought to myself: you really are different… A year ago you wouldn't be able to go to the supermarket! Ever since I started going out, I started feeling less depressed… it is also related to our conversations and changing jobs…* *T: How did you have this idea of going to the museum?* *C: I called my dad and told him: we're going out today!* *T: This is new, isn't it?* *C: Yes, it's like I tell you… I sense that I'm different…*

PERFORMING CHANGE IMS	
Performing change IMs refer to new aims, projects, activities or experiences (anticipated or already acted) that become possible because of the acquired changes. Clients may apply new abilities and resources to daily life or retrieve old plans or intentions postponed due to the dominance of the problem.	*T: You seem to have so many projects for the future now!* *C: Yes, you're right. I want to do all the things that were impossible for me to do while I was dominated by depression. I want to work again and to have the time to enjoy my life with my children. I want to have friends again. The loss of all the friendships of the past is something that still hurts me really deeply. I want to have friends again, to have people to talk to, to share experiences and to feel the complicity in my life again.*

Although some of our studies look at non-therapeutic change in everyday life (Meira, 2009), our main focus has been on brief psychotherapy process (typically of 12 to 20 sessions per case; e.g., Matos et al., 2009; Mendes et al., in press; Gonçalves, Mendes, Ribeiro et al., 2010; Santos et al., 2009)

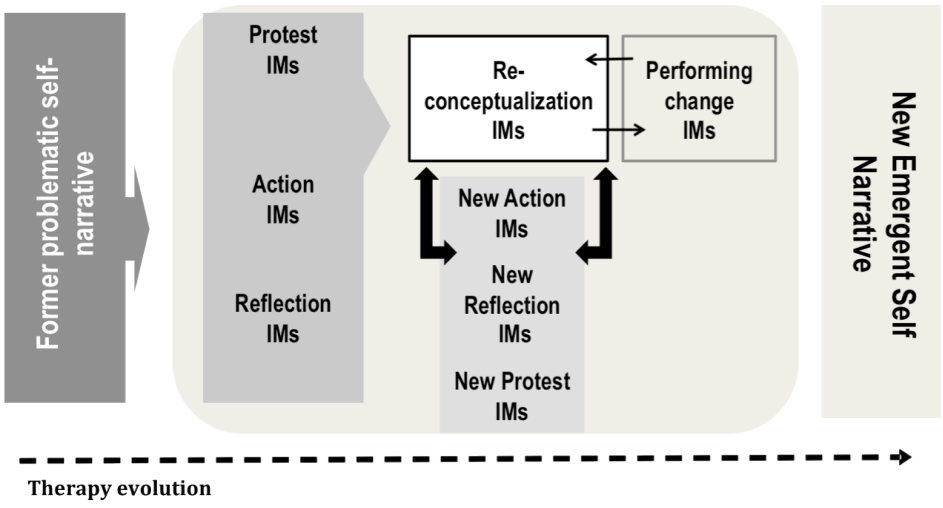
The findings led to setting up a model of IMs' development and progression, typically evidenced in successful therapy cases. According to this model (Gonçalves et al., 2009), the initial signs of narrative change that appear in the first half of treatment (initial sessions) assume the form of action, reflection and protest IMs. More specifically, clients may start by talking about new actions, activities and behaviors that were experimented in their daily life and that challenge the usual expectation of acting according to the problem's prescriptions ('action IMs'). Usually the elaboration upon these actions feeds new thoughts, feelings, intentions and understandings about the problem and its supporters that were not grasped before ('reflection IMs'). Sometimes, the person even enacts in the sessions a more explicit attitudinal refusal or overt critiques against the problem or problem supporters (e.g., certain people or groups allowing the problem, parts of the self endorsing it or giving in to it) in the form of 'protest IMs'. This type of IMs facilitates disengagement between the self and the problem, which reinforces more changes. Moreover, these three types of IMs feed each other in the beginning of treatment, increasing its duration, as the person pays more attention to these new experiences and feels more motivated to defy the problematic narrative, through the enactment and articulation of changes.

An important marker in the change process is the emergence and development of 'reconceptualization IMs' from the middle of therapy until the end, becoming the

dominant type of IM. This is a distinctive feature of successful cases, since reconceptualization IMs are usually absent in unsuccessful cases (to be elaborate below). This is understandable when considering the defining features of this type of IM: the person narrates a contrast between self in the past and self in the present – thus, the client is aware of self-transformation – and also describes the processes that lead to this transition, adopting a meta-perspective about him/herself. Various studies, with different therapy samples and diverse client problems, evidence the emergence of reconceptualization IMs as an important turning point in the change process (Gonçalves, Santos et al., 2010; Gonçalves, Matos and Santos, 2009). This turning-point appears to be characteristic of changes achieved through psychotherapy, a context of which an important defining feature is the dialogue with an interlocutor particularly interested in discussing changes and fostering development. The emergence of reconceptualization IMs feeds new action, reflection and protest IMs that act as signs that further transformations are under way.

Finally, performing change IMs emerge after reconceptualization, emphasizing the projection of changes into the future. These IMs also represent further signs that change is being consolidated and rehearsed, this time in the form of new projects, plans and aims that become possible only because the client became a changed person, with new resources and skills. This global model is depicted in Figure III.1.

Figure III.1: A heuristic model of change and IMs evolution in successful therapy

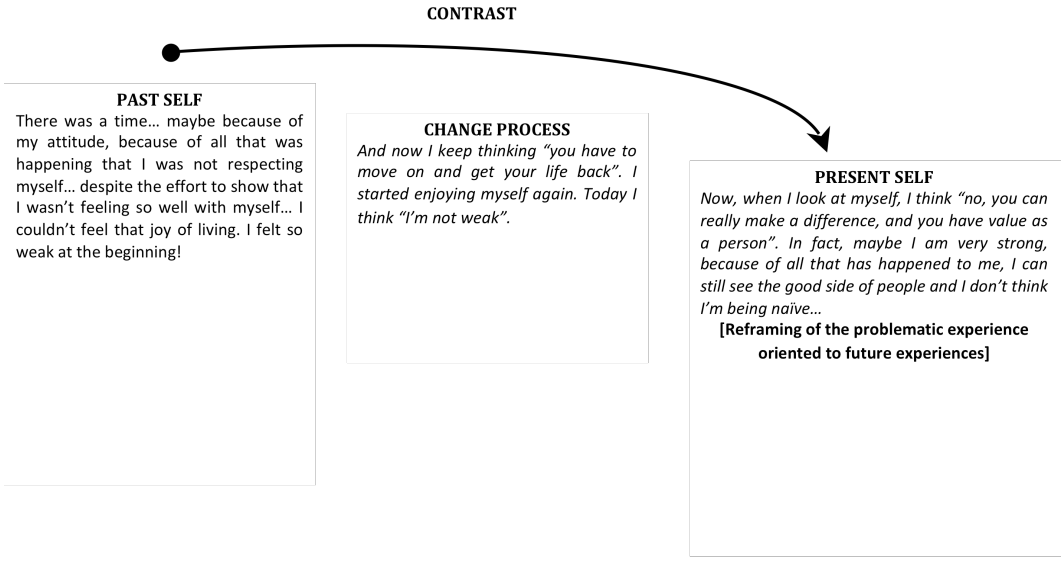


1.2. The centrality of reconceptualization IMs in promoting change

Looking at reconceptualization IMs more deeply, we can distinguish them in terms of *content, dialogical process and narrative structure* (Gonçalves and Salgado, in preparation).

At the level of content, these IMs present two defining characteristics (Gonçalves and Salgado, forthcoming): (a) *contrast in the self* (between past and present) and (b) *access to the change process*, articulated through the viewpoint of a *meta-perspective* of the self. These characteristics serve different psychological purposes in the developing self. First, the contrast expressed in these narratives implies the recognition of an identity rupture – or, at least, a discontinuity in the self (Cunha et al., forthcoming; Zittoun, 2007). Zittoun argues that these perceived ruptures, interruptions or discontinuities can lead to questioning one's personal identity (we realize we are no longer the same as before), and trigger efforts to understand what has happened and reconstitute one's sense of identity, consequently restoring self-continuity. Reconceptualization IMs are attempts to restore self-continuity through disengaging with a previous self-narrative and identifying with a new self-version (Cunha et al., forthcoming; see Figure III.2).

Figure III.2: An example of a reconceptualization IM



Such discontinuity can be unsettling and ambivalent, as the person struggles to achieve new self-familiarity (Cunha et al., forthcoming; Zittoun, 2007). Several trials of reconceptualization IMs might be needed to develop a new self-authorship and consolidate a new self-narrative (see case study in Cunha et al., forthcoming).

Another aspect contributing to the importance of reconceptualization IMs is the enablement of a meta-perspective, or metaposition, in the self. Several authors argue that the potentialities of this meta-perspective view are innumerous for change in psychotherapy (Hermans, 2001, 2003: Gonçalves & Ribeiro, in press). Indeed, this distinguishes reconceptualization IMs in terms of *dialogical process* from other IM types. That is, we have here three positions: the self in the past (old voice), self in the present (new voice), and a third position detached from both and articulating both.

Finally, reconceptualization IMs are distinguishable from novelties like action, reflection and protest by their specific *narrative structure*. As mentioned, the other IMs emerge early in therapy and are usually more discrete and episodic. Through the emergence of reconceptualization, these can become integrated in a more complex narrative that provides a new future orientation, a new sense of agency and authorship grounded in a more positive emotional way of being. Furthermore, it is not rare to notice a positive reframing of problematic or painful experiences (Honos-Webb et al., 2003; Stiles, 2001) within reconceptualization, as these experiences become integrated more constructively, sometimes regarded as learning events or helpful resources in the adaptation to future challenges (Santos and Gonçalves, 2009).

1.3. Mutual in-feeding and ambivalence in the narrative flow

How do people become entrapped in problematic self-narratives? This concern with therapeutic failure is present in almost every model of psychotherapy, and traditionally is addressed in terms of *resistance* (Arkowitz, 2002). However, there is no consensus across models, since each highlights different sets of dimensions that resistance entails. For example, clients may be reluctant to engage in therapeutic tasks, prescriptions and assignments (behavioral resistance), evade certain conversation topics, explore thoughts and feelings or manifest difficulties in comprehending patterns of problematic experiences and relationships (cognitive and/or affective resistance)

(Arkowitz, 2002). Some authors have recently applied an integrative approach to the understanding of this notion (Engle and Arkowitz, 2008; Engle and Holiman, 2002; Messer, 2002). Along with them, we consider resistance as the client's multiple manifestations of core ambivalence towards change.

The notion of *mutual in-feeding* addresses that ambivalence towards change from the IMs' perspective. This concept, derived from Valsiner (2002), refers to the immediate return to a problematic narrative after the expression of an IM (Gonçalves et al., 2009; Santos et al., 2010). In our view, this phenomenon is one of the paths that may lead to a problematic self-stability (or resistance) and ultimately to therapeutic failure. More specifically, mutual in-feeding maintains a dynamic stability between a position and its counter-position (problematic voice and innovative voice), with each feeding the other. This creates a rapid oscillation between opposing positions that, despite being dynamic and interchangeable, is not developmental: 'It becomes developmental only if the relation between parts can permit new parts—and relations between parts—to emerge' (Valsiner, 2002, p. 260). Therefore, this oscillation keeps the person stuck in the movement between innovation and the problematic narrative (Gonçalves, Ribeiro, Conde et al., in press). An example of mutual in-feeding could be: '**I would like to be able to drive again** [*Reflection IM, an innovative voice in a driving phobia*] **but I can't bear the fear** [*return to the problematic narrative*].'

Empirically, such return to the problem may be signaled by *return-to-the-problem markers* (RPMs; Gonçalves, Ribeiro, Conde et al., in press), which are utterances appearing immediately after an IM, denying it (like *but*-sentences). Studies by Gonçalves, Ribeiro, Conde et al. (in press) show that RPMs are more likely to follow IMs in unsuccessful cases than in successful ones, and these differences are visible since the beginning of therapy. Moreover, RPMs frequently followed certain IMs types – like reflection and protest – which seem more vulnerable to mutual in-feeding. RPMs were less likely to follow reconceptualization and performing change IMs, probably because these are markers of sustained change.

The concept of mutual in-feeding conceptualizes resistance as a way to maintain a *status quo* centered on the problem. Engle and Arkowitz (2006, 2008) have similarly explored clients' ambivalence, referring to these instances as *resistant ambivalence.* Like

mutual in-feeding, resistant ambivalence highlights a conflict between changing and remaining the same (see also Arkowitz, 2002; Engle and Holiman, 2002). Ambivalence may appear after the motivated client has already experienced some changes, though its timing in the process may be a little surprising. Nevertheless, these instances of ambivalence should not be looked at negatively as enemies of change (Messer, 2002) but instead as forms of self-protection (Engle and Holiman, 2002). Engle and Arkowitz (2006, 2008) delineate in detail several reasons for not changing. For our purposes, we simplify their elaboration. Resistant ambivalence (or mutual in-feeding) may be evoked by:

(a) Fear and anxiety experienced in the process of changing from something familiar into something unknown;

(b) Conscious or unconscious faulty beliefs about oneself and change;

(c) A reactance to the pressure to change that others may apply (feeling that one's personal freedom is restrained);

(d) Secondary functions or gains produced by the problematic behavior (such as others' attention and care);

(e) Fear of becoming overwhelmed by negative emotions evoked by problematic experiences.

1.4. Enabling a metaposition to deal with ambivalence

Recently, it has been emphasized that psychotherapeutic change is the result of developing the client's self-observation skills (Dimmagio, 2006; Dimaggio et al., 2003). Dialogical Self Theory associates such skills with the activity of a *metaposition* (Hermans, 2001, 2003; Hermans and Kempen, 1993), sometimes referred to as 'observer position' (Leiman and Stiles, 2001) or 'meta-perspective' (Gonçalves et al., 2009). The emergence and expansion of such a position is considered as an important step for promoting healthier dialogues and narratives within the self.

Hermans and Kempen (1993) define a *metaposition* as 'a perspective from which the client phrases the linkages between several significant positions in a self-reflective way' (p. 133). It provides an overarching view upon different aspects of the self, thus

taking a step back from the problematic experience and fostering self-observation: 'A well-developed metaposition … enables clients to separate themselves from the ongoing stream of experiences and to place themselves as authors, considering themselves as actors in specific situations' (Hermans, 2003, p. 122-123). This process creates psychological *distancing*: 'the individual psychologically moves away from the object of perception, such that the object becomes distinct from the self' (Abbey, 2004, p. 32). Acquiring a perspective disengaged from the problematic voice also enables the recognition of one's ambivalences, tensions and conflicts. Therapists' efforts to acknowledge and explore difficulties may provide an opportunity for the emergence of something new. As clients are freer to reflect upon the origin and adequacy of voices resisting change, they may adopt a different attitude to change (Cunha et al., forthcoming). Clients could also understand which valuable needs the voices of ambivalence communicate to the self, welcoming them into dialogue (Engle and Holiman, 2002; Greenberg et al., 1993). Thus, ambivalences can be converted into something productive for the therapeutic process.

Moreover, Hermans (2001) argues that a metaposition can evaluate alternative positions that might have remained hidden or underdeveloped in the shadow of the problematic self-narrative (like *shadow voices* in the self; Gonçalves et al., 2009). This movement of understanding the relation and contrast between positions and how they are integrated (or cast aside) in the dialogical self provides further opportunities to discover or promote relevant linkages among alternative positions and personal history (Hermans, 2001, 2003). We can draw a connection with the functions of reconceptualization mentioned previously, in particular the efforts to restore continuity and unity in the self after the disengagement with the problematic position. In addition, this type of meta-level reflexivity may facilitate the directionality of change into the future, inaugurating a new authorship where new self-positions and possibilities may be construed, including the renewal of self-narratives (Cunha et al., forthcoming; Gonçalves et al., 2009; Hermans, 2001).

2. METHOD

We present three successful cases of clients admitted to brief emotion-focused therapy for depression under the York I Depression Project (Greenberg and Watson, 1998). Several authors present case studies of these clients (Cunha, et al., forthcoming; Honos-Webb et al., 1999; Honos-Webb et al., 2003; Honos-Webb et al., 1998; Gonçalves, Mendes, Ribeiro et al., 2010; Leiman and Stiles, 2001). Below, we look only at their first reconceptualization IMs (expanded in Mendes et al., in press). The selected excerpts represent moments when the self re-evaluates itself and deals with different forms of ambivalence. We have edited these excerpts to eliminate repetitions and speech hesitations, due to space constraints. In all the excerpts, IMs are signaled in italics.

3. RESULTS: CASE EXAMPLES

3.1. Case 1

'Sarah' was a 35-year-old German immigrant in Canada (expanded in Cunha et al., forthcoming; Honos-Webb et al. 2003). She attended 18 therapy sessions. As a part-time college student, recently divorced, she searched for help with her depressive symptoms and increasing sense of isolation. Her main complaints regarded her difficulties of being assertive and of clearly realizing her feelings, and frequently doubting herself. She focused too much on pleasing others and frequently dismissed her own needs.

Excerpt 1: Sarah's first reconceptualization IM

Therapist: So how do you feel?

Sarah: [Reconceptualization IM begins] *Well I'm not too bad, I don't try to sweep away things that much anymore* [Metaposition emerges, observing the self]. *That's I guess one major change which I really like, even so I still find it hard to get going in the mornings* [Remnants of the problematic narrative] *but*...

Therapist: *It's hard to get going, but what did you say, you don't?* [Therapist explores innovation]

Sarah: *Like before well it would get to the point where I would get up and do really basic things and then take a lot of breaks and rest during the day. And that has not really disappeared, but it's simply because I'm so busy, I don't have the chance. And I guess the sudden change – well, it was kind of gradual, I suppose – it leaves me pretty tired for things. But it's kind of a nice change of things.*

Therapist: *So it's hard to get started but once you're into it, it keeps you moving through the day.*

Sarah: *Yeah and I guess the thing really is that, if I'm on my own, I really let it go, let myself go. So I'm trying to keep myself busy and involved, especially with other people. If I have to do something on my own at home, it's just really difficult to get a move on things and well… I don't know, it's just how it works right now.*

Therapist: *So it sounds like you're trying to give yourself some structure that helps you* (Sarah: *Mm-hmm*) *You know you have to be at certain places at certain times.* [Therapist discriminates what is different, helping the client to become more aware and acquire control upon the changes]

Sarah: *Mm-hm, yeah, that kind of puts that certain amount of – I don't know, pressure is maybe not the right word – but I'm aware of what's going on and what's the best way to deal with it.* (Therapist: *Mm-hm.*) *So that really helps and also I'm kind of getting the hang of it, like what makes me uncomfortable when I'm with other people and really try my best, as soon as I notice it* [i.e. discomfort in interpersonal situations] *to deal with it. To let them know that 'No, this is not acceptable to me' or 'No, I*

can't deal with it for whatever reason' but it's just too much and it works really well (laughs)

Therapist: *So it sounds like two things are different: one is that you're able to notice it quicker* (Sarah: *Mm-hm.*) *or you are able to make sense of something making you uncomfortable, and then you come out and set your limits and do something about it.*

Sarah: *Mm-hm, even though this creates* (client interrupts with a small pause, letting the therapist infer about some *negative feelings*) *at the time, I know 'Ok, right now this is it. I have to do or say something, otherwise it's going to happen again* (…) *So I get kind of tense about it but then I say or do whatever it is. And it's just, I can't believe how difficult I find it to do this, like to be assertive* (Therapist: *Mmm.*) *about things.* [Reconceptualization IM ends here – Ambivalence expressed by a meta-position in the self, reflecting upon the self as changing; underlined]

Therapist: So it feels like it shouldn't be so difficult.

Sarah: Yeah because I feel kind of guilty about it. (Therapist: Mm-hm.) Um, for somewhere around a day almost [i.e. questioning, doubting herself]. Was I entitled really to do this? You know, did I hurt the other person? [Mutual in-feeding, underlined – Return to the problematic narrative, as self-doubt appears]

Therapist: Mm-hm.

Sarah: [Reflection IM begins] *It's always like I'm more concerned about what I do to the other person than saying 'Well, this is me, I have to look at myself first, other people are doing it and I have to let them know where the limit is, that they have to look for a different approach or that they definitely overstepped it'* [Metaposition, observing the self]

Therapist: *It sounds like at the time you're able to do that, to set your limits and yet you're left with this disconcerting feeling like 'Maybe I shouldn't have, maybe I hurt them', that kind of thing?*

[Therapist acknowledges difficulties and mirrors the ambivalence to the client]

Sarah: *Yeah, but then the next time when I encounter them I notice in their behavior that they know and acknowledge it.* [Metaposition differentiating] *I put something forward and they just have to live with it, to acknowledge it. I kind of staked out the border or indicated the limits, how far they can go. I mean, there are a few things happening last week and this week and, now when I think about it, 'My gosh, I'm just so glad I did it!' And I guess it's a start.*

Therapist: *So, you're saying, the guilty feeling in a way doesn't last too long. In the end, when it's all said and done, you're happy.* [Reflection IM ends here]

In the excerpt above (excerpt 1), taken from Session 7, Sarah begins by expressing how she has already achieved some changes in interpersonal situations. She presents herself as more assertive, which triggers a reconceptualization IM. She highlights the contrast between present and past. She also elaborates upon what is different even though some problems remain (*I still find it hard to get going in the mornings*). Her therapist acknowledges these difficulties but leads Sarah to explore innovation. This is performed afterwards in several turns of the conversation: Sarah reports changes, denotes some remnants of the problem, but proceeds to expand the elaboration upon innovation; the therapist acknowledges difficulties, but proceeds to pointing out and clarifying what is different.

It is then that a more pronounced marker of ambivalence to change emerges in the midst of reconceptualization: although adopting a meta-reflective stance and observing herself as a changed actor, Sarah discloses to her therapist how she never thought that acting in the desired, changed way, would be so difficult (*I can't believe how difficult I find it to do this, like to be assertive*). The therapist is responsive to her difficulties and proceeds to explore them (*it feels like it shouldn't be so difficult*). Now, the ambivalence fully differentiates into the process of mutual in-feeding, circumventing

reconceptualization: the client returns to the problematic narrative, manifesting guiltiness and self-doubts (*I feel kind of guilty about it*).

Yet, this step back into the usual problematic functioning is not long, as the client's metaposition evolves to noticing how others react to a changing Sarah and moves along to an assertion of her own needs, this time, in the form of a reflection IM. And despite the fact that Sarah's therapist keeps acknowledging her difficulties and mirroring the ambivalence to the client (*yet you're left with this disconcerting feeling like 'Maybe I shouldn't have'*), Sarah is already in motion in a reinvigorated emphasis on change (*I'm just so glad I did it! And I guess it's a start*) that motivates further innovation in the process.

3.2. Case 2

'Jan' was a 42-year-old white female, working as a sales person (expanded in Honos-Webb, et al. 1999; Gonçalves and Ribeiro, in press). She attended 16 therapy sessions, and was considered clinically depressed. The most important symptoms to her were lack of motivation at work, and some psychosomatic complaints such as hives (urticaria) and difficulties swallowing. During therapy, Jan understood that her symptoms were frequently signs of the burden she placed on herself in work and family environments, as she took extra responsibility for taking care of everyone and catered too much for others' needs.

In the excerpt below (excerpt 2), taken from Session 4, Jan discloses that her hives came back after a brief remission in the first weeks of psychotherapy. By this time, Jan had already made some progress towards change and the symptoms' return troubles her.

Excerpt 2: Jan's first reconceptualization IM

Jan: My hives came back this week again – I thought they were sort of gone but I had two, three days where, you know, they were back. I still have them but that two, three days were worse than before. So that caused, you know, sort of a little bit of worry

[Ambivalence starts to emerge implicitly in the form of a negative feeling, underlined]

Therapist: Mm, about?

Jan: That <u>they're going to come back as bad as they were before, and I'm not getting anywhere</u> [Ambivalence in the form of fear of failing to change, underlined – Problematic narrative]

Therapist: Mm-hm, so the hives kind of tell you that maybe

Jan: [Reconceptualization IM begins] *I think that's a trigger point* [Metaposition, observing the self] (Therapist: *Yeah*) *I think I've accepted it that the hives are something that subconsciously my body is telling me – that I have to do something – um, make some changes* (Therapist: *Mm-hm.*) *you know, whichever they are*

Therapist: *That's sending you a message*

Jan: *Mm-hm. I just have to listen to it and not ignore it like I have in the past*

Therapist: *Mm-hm. So it's kind of an important sign that something's going on* [Therapist reinforces client's insight]

Jan: *Yeah, I think that's the only thing, really the hives are the only thing that's really triggering it for me, because it's visual*

Therapist: *Mm-hm, so you can really see that something's going on*

Jan: *Mm-hm. I can't ignore it as much as* (Therapist: *Mm-hm.*) *you know, I can ignore a headache or a pain in my neck or something like that* [Reconceptualization IM ends here]

As Jan talks about the hives, she expresses how these symptoms triggered some negative feelings again (worry) and ambivalence towards change starts to emerge implicitly. This ambivalence could have evolved to a case of mutual in-feeding but, in this case, Jan's concerns are more focused on a fear of failing to change despite her efforts and therapeutic help. Her therapist, acknowledging these difficulties, leads Jan to explore them further. And this is where the metaposition appears, and Jan elaborates a

reconceptualization IM. Through this metaposition, Jan discovered something new about her problems (*I think that's a trigger point*) which allows a reframing of the symptoms: they are, after all, bodily signs that indicate a need to persevere and keep changing (*I just have to listen to it and not ignore it like I have in the past*), instead of a marker of failure. This interesting movement towards constructing the symptom as an important, positive sign is the result of an intersubjective process between client and therapist (initiated in earlier sessions), whose interventions reinforce and validate Jan's view (*So it's kind of an important sign that something's going on*).

3.3. Case 3

'Lisa' was a 27-year-old woman with an Italian background, married and with two children (expanded in Gonçalves, Mendes et al., 2010; Honos-Webb et al., 1998; Leiman and Stiles, 2001). She attended 15 therapy sessions. Lisa was considered clinically depressed, and her main complaints regarded sadness, resentment and guilt towards her husband and his gambling problem.

Lisa presents reconceptualization IMs starting from Session 1 (Gonçalves, Mendes et al., 2010, give a detailed analysis of IMs development in this case). Here she explores her difficulties with her husband and children (excerpt 3):

Excerpt 3: Lisa's first reconceptualization IM

Therapist: And yet, it's still there, like somehow there's this feeling of… (…) Can you talk about that a bit, just what it's like?

Lisa: Um, [Metaposition emerges, observing the self] I feel like I'm the provider, I'm there (in the marriage) for only that reason. (Therapist: uh-huh) Not so much that, you know, he wants to be with me, it's more that the kids are here and this is the way it's got to be and (Therapist: uh-huh) and that's, there's no way of escaping that (…)

Therapist: So you start almost feeling helpless

Lisa: That's right, I'm helpless about it, I can't do anything

Therapist: Feels like there's just no way out (…) Because you still end up feeling hurt inside

Lisa: Yeah, the feelings are very much there even though I understand the disease [i.e. the gambling habit] and the character in him (Therapist: yeah) [Reconceptualization IM begins, in italics] *and I believe that he can be helped but he doesn't see it or he doesn't want it. And I've stopped changing him, I don't want to change him anymore, because you know I'm just looking at my own problems*

Therapist: *Uh huh, so rather than try to control his behavior, it's more like*

Lisa: *Right, I don't do that anymore, I don't do that as much as I used to*

Therapist: *You just focus on yourself and what you feel*

Lisa: *Yeah, myself and what's happening at that moment* (Therapist: *Mm-hm.)* [Reconceptualization IM ends here]

Lisa: When he says I'm going out or like last Sunday (…) [Describing how her husband had arrived late to a scheduled activity with the children and then she questioned him about that] He said 'Oh, I was having a card game' and that just brings the feelings back, like you know, your family and kids come first!

Therapist: Mmm, so there's almost a feeling of resentment

Lisa: Yeah, it's very strong, and I don't cut him up or anything, I never have

Therapist: Yeah, you don't want to start yelling at him (…) So I guess it just kind of feels like, even though there's this boiling kind of feeling inside 'I'm not going to tell him because (Lisa: Yeah) it's not going to do any good, it's not my responsibility anymore' (...) So it sounds like you've gone and given up

Lisa: Yeah I do at this point

Therapist: He's not going to change

Lisa: No, I don't see it. Um, *I don't know if I should be out there trying harder but I think I've given up.* [Reflection IM, in italics – Ambivalence appears in the form of self-doubt, underlined] (Therapist: uh-huh) In that sense, I've kind of let God take over

Therapist: Uh-huh, so there's a feeling of 'I gave up' and somehow there's sadness that comes to mind (Lisa crying: Mm-hm.) Sort of as if you've lost something, I'm not sure

Lisa: Yeah, I don't know what, but failure comes up to me [Mutual in-feeding, underlined – Remnants of the problematic narrative]

Therapist: Uh-huh, it feels like you should have been able to

Lisa: Yeah, something doesn't connect

Therapist: Um, like you're not connecting with him, you're not getting through to him. Um, it's like trying to get close to a brick wall

Lisa: *Yeah, and I just don't want to get too close because* (crying), *I guess I don't want to be hurt more.* (Therapist: *Uh-huh*) *Maybe that's why I've given up* [Reconceptualization IM in italics]

The therapist tries to explore her emotional experiences in the marriage. This triggers a metaposition, as Lisa starts observing herself in her marital relationship (*I feel like I'm the provider*; *There's no way of escaping*). The therapist keeps helping Lisa to explore emotions associated with this relationship and, as she further observes herself, the first reconceptualization IM appears. From this point on, and with the therapist's help, it is clear that Lisa wants to disengage from her husband's problems and to focus more on herself, in contrast with what she used to do.

Nevertheless, as Lisa talks about when her husband was late to something he had planned with their children, we see that rage and resentment towards her husband are still very much present in their daily life. The therapist introduces the notion of *giving up* old patterns, while trying to specify what has been changed in the way the couple interacts (*So it sounds like you've gone and given up*). Here Lisa starts expressing some ambivalence. She begins by doubting her decision to distance herself from her husband's

problems (*I don't know if I should be out there trying harder*), but immediately repositions herself, refusing responsibility (*I've kind of let God take over*). The therapist opts not to pursue this distancing movement, but explores further the ambivalence, looking for negative emotions. This activates mutual in-feeding, as traces of the problematic narrative emerge (failure for not being able to change her husband) in the form of a self-critical voice. Through this, we notice that Lisa is still very linked to the usual functioning of the relationship. But then the therapist introduces a powerful metaphor (*it's like trying to get close to a brick wall*) that reactivates the client's metaposition, potentiating another reconceptualization IM and a new insight about the problem (*I just don't want to get too close because I don't want to be hurt more.*).

3.4. Synthesis

As the three vignettes show, ambivalence is a common companion of the therapeutic process as clients readjust their own identity trying to accommodate recent changes. Despite this commonality, we believe that these three excerpts present different types of ambivalence, emerging at different moments of the change process and playing different roles in it.

In Sarah's case, the first reconceptualization IM appeared in session 7; that is, in the middle of the psychotherapy process. The client initiated the therapeutic dialogue in this session by presenting herself as a changed person (i.e., more assertive). Despite her acknowledgment of some difficulties, there was a perceived rupture in the self, created by the identification with a new way of behaving. Along the elaboration of this innovative way of acting and being, Sarah's therapist intervened by validating the changes and helping Sarah to understand how these have been set in motion. In her case, ambivalence emerged at the end of reconceptualization, as she adopted a metaposition and started reflecting upon how she felt during and after the performance of the changes. Thus, we believe that the type of ambivalence exhibited by this client was expressed by a metaposition as a reaction to some unexpected difficulties concerning the enactment of changes. The ambivalence expressed by this meta-perspective was picked upon as a cue by her therapist that decided to explore these difficulties, instead of pursuing the elaboration around changes, as she did before. The acknowledgment of difficulties lead,

then, to a full return to the problem – the process of mutual in-feeding – as the client disclosed feeling guilty to act assertively and doubting her right to change in her interpersonal relationships. Yet, as soon as Sarah revisited the problematic position, she immediately repositioned herself again as changed, initiating a reflection IM, where she reaffirmed her right to express herself and other people's duty to acknowledge her views. Therefore, we consider that the ambivalence and mutual in-feeding seen in this excerpt acted as recursive movements of revisiting the past (i.e. the problematic narrative) that, instead of perpetuating problems, renovated the motivation in the direction of further changes (i.e. the adoption of an innovative position and a new self-narrative).

In contrast, in Jan's case, the first reconceptualization IM appeared in Session 4; that is, in the initial phase of the psychotherapy process. Given that she had already experienced some changes in the form of a symptomatic reduction during the first four weeks of therapy, the fact that the hives came back again triggered implicit ambivalence towards the possibility of effective change. In this case, we believe that the client's ambivalence – expressed as a vague apprehension towards the meaning of the symptoms' return – was the manifestation of a fear of failure and of remaining powerless to overcome the problem despite personal efforts to change and seeking therapeutic help. The fact that Jan was then able momentarily to disengage from these doubts, and adopt a metaposition towards the event, led to an interesting insight about the symptom that reframed the meaning Jan had attributed to it. Specifically, whereas before the hives could mean the problem regaining control in her life, from that moment on Jan was able to construe the possibility that the symptoms actually act as basic expressions of unattended affective and bodily needs. Consequently, this intersubjective reframing of the symptoms' meaning promoted a renewed hope in her and encouraged her to persevere towards change.

Finally, in case of Lisa, the first reconceptualization IM emerged in the first session, the very beginning of the psychotherapy process, in distinct contrast with the other cases. In this case, the metaposition emerged initially, with Lisa reflecting upon her role in the marriage and how she used to react to her husband. The therapist helped her to understand how she needed to focus more on herself and her feelings. As Lisa tried to distance herself from her husband's problems in her first reconceptualization IM, we saw

her taking the first steps to hold him accountable for his gambling habit and parenting choices. However, this initial assertive movement led to the emergence of ambivalence, appearing under the form of a self-critical voice that questioned her right to emphasize her needs, and eliciting the sense of failure as a wife giving up on her husband. In an attuned emphatic movement, Lisa's therapist sensed how poignant these negative feelings were, and acknowledged them, giving room for their expression and exploration in the therapeutic dialogue. Yet, it was the use of a powerful metaphor that resonated with Lisa's internal experience (like getting close to a brick wall) that restored the path to narrative innovation, potentiating another reconceptualization IM in the client. We consider that this challenging movement was very productive in the repositioning of Lisa back to a focus on herself and the reaffirmation of the legitimacy of her needs.

Given these cases, we may consider three different types of ambivalence: 1) mutual in-feeding, as clients doubt whether to change or remain the same (exhibited by Sarah and Lisa); 2) ambivalence related to the fear of failure in the path to change (Jan); and 3) ambivalence expressed by a metaposition, related to the difficulties triggered by changes (Sarah). Furthermore, ambivalence may appear before (Jan), after (Lisa) or during (Sarah) a reconceptualization IM, when the client adopts the metaposition. In turn, the metaposition can also appear before (Lisa) or more usually during the reconceptualization IM (the other two cases). Regardless of the onset of the metaposition, all the vignettes illustrate that the differentiation and elaboration of the metaposition's perspective permitted the dissolution of ambivalence, and frequently led to further innovation (in the form of reflection or another reconceptualization IMs). This interpretation is in line with other authors' argument for the developmental potential of a metaposition as facilitating therapeutic change (Gonçalves et al., 2009; Hermans, 2001, 2003; Engle and Arkowitz, 2006; 2008; Leiman and Stiles, 2001).

Despite the specific therapeutic interventions exhibited in these situations, we would probably benefit from a more systematic analysis of specific interventions that are more fitted to address ambivalence and transform it productively, promoting a differentiation of the metaposition and facilitating a positive evolution of the therapeutic process. Therefore, an interesting avenue of research in the future could be the pursuit of more intensive case-studies and conduct a systematic comparison of therapeutic episodes

in them. This could lead to a more precise discrimination of therapeutic interventions more fitted to match certain types of ambivalence, in order engage the opposing voices in dialogue and to enhance self-observation skills in client, facilitating the development of a metaposition and psychological distancing from problems.

4. CONCLUSION

In this chapter we claimed that ambivalence is a persistent feature of the change process, acquiring multiple shapes throughout therapy evolution. Thus, therapists need to be prepared for recognizing the different forms how it can materialize in dialogue – either the mutual in-feeding between problematic and innovative voices or other forms of ambivalence towards change, mainly gravitating around fear and uncertainty towards the future.

We have argued that the differentiation and development of a metaposition in the self is an important tool to deal with this ambivalence and resistance to change, though more systematic studies are needed in order to understand its development and function. This position can not only help to understand ambivalent voices in psychotherapy, acknowledging the underlying self-protective needs that these ambivalent voices can express but also, most importantly, discover how to surpass them and to foster further changes. It is then, in the delicate balance between old and new, gradually abandoning old voices and rehearsing new ones, where new self-narratives become a possibility and self-development becomes a fact.

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CHAPTER IV

RECONCEPTUALIZATION AND ASSIMILATION ON THE SPOTLIGHT: HOW CAN ONE PSYCHOTHERAPY CHANGE MODEL INFORM ANOTHER?

CHAPTER IV

RECONCEPTUALIZATION AND ASSIMILATION ON THE SPOTLIGHT: HOW CAN ONE PSYCHOTHERAPY CHANGE MODEL INFORM ANOTHER?[9]

1. ABSTRACT

This study explored reconceptualization innovative moments in a sample of emotion-focused therapy (EFT) for depression, through the lens of the assimilation model. The systematic analysis of 108 reconceptualization innovative moments in six cases shows that these narratives can be assessed with a wide range of stages within the Assimilation of Problematic Experiences Scale, starting from level 1 and reaching levels as high as 7. However, the majority of reconceptualization innovative moments were coded with assimilation levels 4 to 6 (88%). The assimilation of problematic experiences within reconceptualization innovative moments generally increased along the treatment, particularly in the good outcome EFT cases. The implications of these findings are discussed suggesting that assimilation ratings can be used as a way of differentiating the productivity of reconceptualization innovative moments.

2. INTRODUCTION TO STUDY 4

This article studies the assimilation levels of reconceptualization innovative moments (Gonçalves, Matos & Santos, 2009; Gonçalves, Ribeiro, et al., 2011; Osatuke & Stiles, 2006; Stiles, Meshot, Anderson & Sloan, 1992). Within the Innovative Moments model, findings from previous studies have been consistently relating the presence of reconceptualization IMs with good outcome therapy (Alves et al., in press; Gonçalves, Mendes, et al., 2010, 2011; Matos, et al., 2009). However, previous case studies have suggested that reconceptualization is a heterogeneous entity, changing itself throughout the therapeutic process. The present study uses the Assimilation Model as a way to capture the differentiation of reconceptualization innovative moments and how they

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evolve along different therapy phases in a sample of emotion-focused therapy (EFT) for depression. This may be relevant to help researchers and therapists to assess the productivity of reconceptualization innovative moments and the processes that increase the probability of successful change in depressed clients.

2.1. The Innovative Moments Model: Theory and research

The Innovative Moments model (Gonçalves, Matos & Santos, 2009; Gonçalves, Ribeiro, et al., 2011), inspired in the narrative metaphor of psychotherapy (Angus & McLeod, 2004; White & Epston, 1990; White, 2007), understands the self as a narrative achievement. In this line of reasoning, human beings make sense of their experiences and events by organizing them into self-narratives (Gonçalves, Matos & Santos, 2009; Neimeyer, Herrero & Botella, 2006). Usually, self-narratives provide coherence to the flow of significant life events, though remaining flexible enough to encompass discrepant experiences. Yet, self-narratives may sometimes become *problematic* when they loose this ability to flexibly integrate more challenging experiences and meanings. These problematic self-narratives that clients bring in the beginning of therapy are usually centered on problems and deficits, being dismissive of discrepant experiences (White & Epston, 1990).

According to the Innovative Moments model (Gonçalves, Matos & Santos, 2009; Gonçalves, Ribeiro, et al., 2011), *innovative moments* (IMs) are exceptions to these problematic self-narratives. More specifically, IMs appear any time the client acts in contrast to the behaviors, thoughts and emotions prompted by the problematic self-narrative. The Innovative Moments coding system (Gonçalves, Ribeiro et al., 2011) allows identifying five types of IMs: *action, reflection, protest, reconceptualization and performing change* (table IV.1).

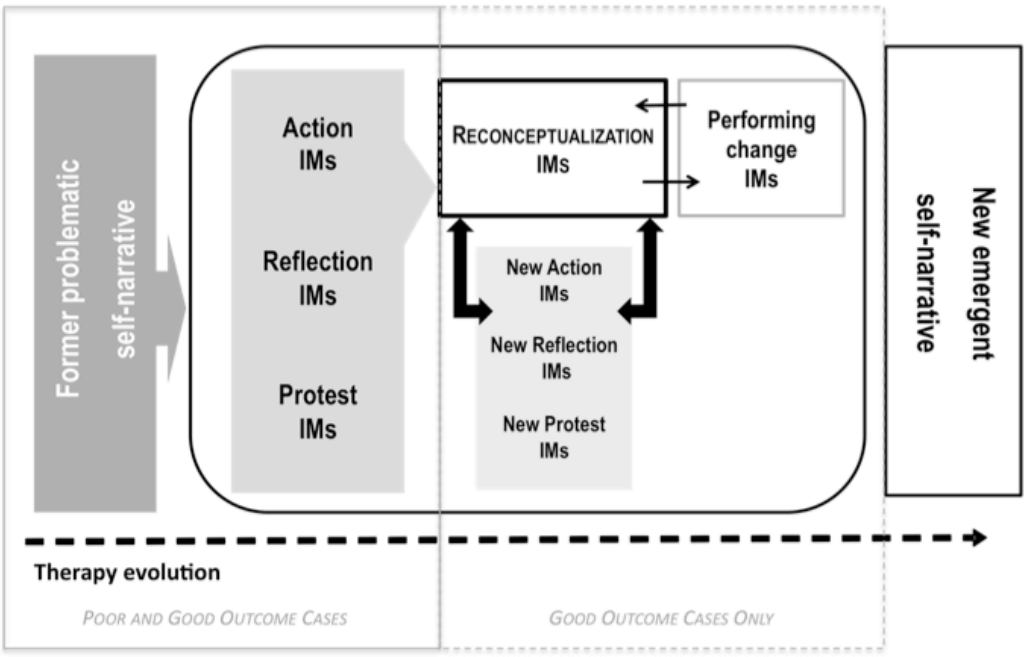
Table IV. 1: The Innovative Moments Coding System

(Adapted from Gonçalves, Mendes, et al., 2010)

Types of Innovative Moments	**Examples** (Problematic narrative: depression)
ACTION IMS	
Action IMs refer to events or episodes when the person acted in a way that is contrary to the problematic self-narrative.	*C: Yesterday, I went to the cinema for the first time in months!*
REFLECTION IMS	
Reflection IMs refer to new understandings or thoughts that undermine the dominance of the problematic self-narrative. They can involve a cognitive challenge to the problem or cultural norms and practices that sustain it or new insights and understandings about the problem or problem supporters. These IMs frequently can also assume the form of new perspectives or insights upon the self while relating to the problem, which contradict the problematic self-narrative.	*C: I realize that what I was doing was just, not humanly possible because I was pushing myself and I never allowed myself any free time, uh, to myself … and it's more natural and more healthy to let some of these extra activities go…*
PROTEST IMS	
Protest IMs involve moments of critique, confrontation or antagonism towards the problem and its specifications and implications or people that support it. They can be directed at others or at the self. Oppositions of this sort can either take the form of actions (achieved or planned), thoughts or emotions, but necessarily imply an active form of resistance, repositioning the client in a more proactive confrontation to the problem (which does not happen in the previous action and reflection IMs). Thus, this type of IMs entails two positions in the self: one that supports the problematic self-narrative and another that challenges it. These IMs are coded when the second position acquires more power than the first.	*C: I am an adult and I am responsible for my life, and, and, I want to acknowledge these feelings and I´m going to let them out! I want to experience life, I want to grow and it feels good to be in charge of my own life. I am not going to put up with this anymore!*
RECONCEPTUALIZATION IMS	
Reconceptualization IMs always involve two dimensions: a) a description of the shift between two positions (past and present) and b) the transformation process that underlies this shift. In this type of IMs there is the recognition of a contrast between the past and the present in terms of change, and also the ability to describe the processes that lead to that transformation. In other words, not only is the client capable of noticing something new, but also capable of recognizing oneself as different when compared to the past due to a transformation process that happened in between.	*C: You know… when I was there at the museum, I thought to myself: you really are different… A year ago you wouldn't be able to go to the supermarket! Ever since I started going out, I started feeling less depressed… it is also related to our conversations and changing jobs…* *T: How did you have this idea of going to the museum?* *C: I called my dad and told him: we're going out today!* *T: This is new, isn't it?* *C: Yes, it's like I tell you… I sense that I'm different…*
PERFORMING CHANGE IMS	
Performing change IMs refer to new aims, projects, activities or experiences (anticipated or already acted) that become possible because of the acquired changes. Clients may apply new abilities and resources to daily life or retrieve old plans or intentions postponed due to the dominance of the problem.	*T: You seem to have so many projects for the future now!* *C: Yes, you're right. I want to do all the things that were impossible for me to do while I was dominated by depression. I want to work again and to have the time to enjoy my life with my children. I want to have friends again. The loss of all the friendships of the past is something that still hurts me really deeply. I want to have friends again, to have people to talk to, to share experiences and to feel the complicity in my life again.*

Findings derived from previous studies (Alves et al., in press; Gonçalves, Mendes, et al., 2011; Matos, et al., 2009; Mendes et al., 2010) with different therapeutic modalities lead Gonçalves and collaborators to depict a model of narrative change from the IMs' point of view (Gonçalves, Matos & Santos, 2009; Gonçalves, Ribeiro, et al., 2011 – figure IV.1).

Figure IV. 1: A heuristic model of therapeutic change from the IMs' point of view (Adapted from Gonçalves, Matos & Santos, 2009)



According to this view, narrative change requires the emergence of IMs in a specific pattern consistently found in successful (i.e. good outcome) psychotherapy cases (Gonçalves, Mendes, et al., 2011; Matos et al., 2009; Mendes et al., 2010). In successful therapy, the first signs of narrative change appear in the form of action, reflection and protest IMs. Even though the sequence between these IMs may vary, these types are the first to emerge in the initial sessions. Usually the client begins with reflection IMs, reflecting on the problem and its constraints and then present new behaviors (action IMs), inconsistent with the problematic self-narrative. Protest IMs tend to occur after the

emergence of reflection and action IMs, although other times these IMs appear from the beginning (particularly in EFT – Mendes et al., 2010). Reconceptualization IMs usually emerge in the middle phase of therapy, and become the more predominant type of innovation until the end. Finally, performing change IMs appear after reconceptualization, as clients start projecting new plans and projects into the future, frequently rescuing former parts of themselves that were undeveloped due to the dominance of the problematic self-narrative.

2.2. The role of reconceptualization IMs in the evolution of therapeutic change

Previous studies using the *Innovative Moments Coding System* (IMCS – Gonçalves, Ribeiro, et al., 2011), have been pointing to reconceptualization IMs as markers of successful therapy. Two findings support this argument. First, reconceptualization IMs are almost absent (or completely absent) in unsuccessful (i.e. poor outcome) therapy of different modalities (narrative therapy – Gonçalves et al., 2009; Matos et al., 2009; emotion-focused therapy – Gonçalves, Mendes et al., 2011; Mendes et al., 2010; client-centered therapy – Gonçalves, Mendes, et al., 2011). Second, they typically increase their emergence from the middle to the final phase of successful (i.e. good outcome) psychotherapy (Alves et al., in press; Gonçalves, Mendes, et al., 2011; Matos, et al., 2009; Mendes et al., 2010), usually becoming in the final phase the most predominant type of innovation.

At this point, we are faced with the question: Why is reconceptualization so important for the change process? In our view, reconceptualization is accomplished by the adoption of a metaperspective upon the self (Gonçalves, Matos & Santos, 2009). This ability of clients to take a step from, and reflect upon, their current state requires a form of *distancing* from the problematic pattern (Abbey, 2004; Cunha et al., in press; Cunha, Gonçalves & Valsiner, 2011). Adopting a metaperspective allows the recognition of a contrast in the self and the access to the transformation process. That is, clients acknowledge a contrast between the present and the past by talking about themselves as currently different than they were before, and also clarify the transformation process that allowed them to arrive at this point in their lives (e.g. the importance of persisting to change, seeking for therapeutic help, etc.). These distinctive features are what make

reconceptualization a key process for self-narrative change. This view is consistent to other authors' recent suggestion that this self-observation process, carried out by an *observer position* (Leiman, in press) or by a *metaposition* (Hermans & Hermans-Jansen, 2004), with heightened meta-cognitive abilities (Dimaggio, et al., 2003, 2007), is very productive to facilitate the change process.

Moreover, when elaborating further upon the importance of reconceptualization, Gonçalves and Ribeiro (in press) proposed that it has four main developmental functions. It provides a *narrative structuring of the change process* (1st function), as these IMs achieve a more complex narrative structure and are closer to a narrative product (i.e. a story about the changing self) through the diachronic sequencing of temporally organized events (Hermans, 1996, 2003). Reconceptualization IMs also allow the *achievement of self-continuity through the contrast* in the self (2nd function), given that clients acknowledge themselves no longer as they were in the past but also can make sense of the transformation process that explains this discontinuity (see also Cunha et al., in press; Zittoun, 2007). In addition, the repetition of reconceptualization IMs potentiates the *identification with a new self-narrative* (3rd function), as clients rehearse and become familiarized with a new identity that consolidates prior achievements (Cunha et al., in press). Finally, reconceptualization IMs facilitate the resolution of ambivalences appearing in the change process (Cunha, Gonçalves & Valsiner, 2011; Gonçalves, Ribeiro, Stiles, et al., 2011), given that they integrate past with the present self.

However, prior case studies have evidenced that the multiple reconceptualization IMs do not remain exactly the same throughout the therapy process – in other words, reconceptualization seems to be a heterogeneous entity. More specifically, in a later study on the presence of ambivalence in reconceptualization IMs, an intensive analysis found evidences of different forms of ambivalence appearing in the initial reconceptualization IMs from three successful EFT cases (Cunha, Gonçalves & Valsiner, 2011). Additionally, Cunha and colleagues (in press) proposed the idea that reconceptualization IMs change in the therapy process as a product of its recursion and repetition along the treatment, which allows the differentiation of some of its qualitative features (i.e., the progressive disengagement with the past self-narrative, the increasing identification with a new one, and the resolution of ambivalences). Together, these studies proposed the idea

that recursivity of reconceptualization IMs is an important process to consolidate a new self-narrative in the substitution of a former one.

Moreover, the previous findings lead to new hypotheses, which will be pursued in this study: i) reconceptualization IMs exhibit a significant qualitative differentiation along the therapy process and ii) the recursivity of reconceptualization IMs is important for the improvement of these IMs' productivity along the EFT treatment. Therefore, the systematic analysis of reconceptualization IMs can be useful to clarify how these narratives become differentiated throughout therapy. We propose that these qualitative differences can be captured with another reliable method to study psychotherapy change – i.e. the assimilation model – which can also serve as a tool for assessing the productivity of these IMs (acting as an external validity measure – Campbell, 1986; Greenberg, 2007).

2.3. The present study: Using the assimilation model to further understand the evolution of reconceptualization IMs in therapy

According to the *Assimilation model*, therapeutic change is achieved through the process of assimilation (Honos-Webb & Stiles, 1998; Stiles, et al., 1990). The notion of assimilation refers to the progressive integration of a problematic experience or the acceptance of a problematic voice into the community of voices that constitutes the self (Caro-Gabalda, 2008; Stiles, 1999; Stiles, et al., 1990). Prior intensive psychotherapy case studies (or interpretive studies – Stiles, 2001) departed from a conceptual analysis of clients' problems and studied their evolution, leading to the description of eight different stages or levels in the assimilation process depicted in the *Assimilation of Problematic Experiences Sequence/Scale* (also known as APES – table IV.2; Stiles, 1999, 2001). These eight levels of the APES describe a sequence of qualitatively distinct stages of assimilation (Stiles, 2001; Osatuke & Stiles, 2006) and successful therapy usually facilitates the progression from lower to higher levels of assimilation, regarded as therapeutic improvement (Brinegar, et al., 2006; Caro-Gabalda, 2005, 2008; Stiles, 2001; Osatuke, et al., 2005). Good outcome cases tend to reach at least APES level 4, in contrast with poor outcome cases (Detert, et al., 2006).

Table IV. 2: Assimilation of Problematic Experiences Scale

(Osatuke & Stiles, 2006, p. 292)

ASSIMILATION OF PROBLEMATIC EXPERIENCES SCALE (APES)
0. WARDED OFF/DISSOCIATED.
Client is unaware of the problem; the problematic voice is silent or dissociated. Affect may be minimal, reflecting successful avoidance. Alternatively, problem may appear as somatic symptoms, acting out, or stare switches.
1. UNWANTED THOUGHTS/ACTIVE AVOIDANCE.
Client prefers not to think about the experience. Problematic voices emerge in response to therapist interventions or external circumstances and are suppressed or avoided. Affect is intensely negative but episodic and unfocused; the connection with the content may be unclear.
2. VAGUE AWARENESS/EMERGENCE.
Client is aware of a problematic experience but cannot formulate the problem clearly. Problematic voice emerges into sustained awareness. Affect includes acute psychological pain or panic associated with the problematic material.
3. PROBLEM STATEMENT/CLARIFICATION.
Content includes a clear statement of a problem – something that can be worked on. Opposing voices are differentiated and can talk about each other. Affect is negative but manageable, not panicky.
4. UNDERSTANDING/INSIGHT.
The problematic experience is formulated and understood in some way. Voices reach an understanding with each other (a meaning bridge). Affect may be mixed, with some unpleasant recognition but also some pleasant surprise.
5. APPLICATION/WORKING THROUGH.
The understanding is used to work on a problem. Voices work together to address problems of living. Affective tone is positive, optimistic.
6. RESOURCEFULNESS/PROBLEM SOLUTION.
The formerly problematic experience has become a resource, used for solving problems. Voices can be used flexibly. Affect is positive, satisfied.
7. INTEGRATION/MASTERY.
Client automatically generalizes solutions; voices are fully integrated, serving as resources in new situations. Affect is positive or neutral (i.e., this is no longer something to get excited about).

Given that the assimilation of problems is regarded as a continuum of levels, it might be useful to grasp the differentiation of reconceptualization IMs during therapy. Thus, our overall purpose for the present study was to explore the diversity of reconceptualization IMs (RC IMs) through the analysis of the APES levels attributed to these IMs and how they evolve along different therapy phases. More specifically, we investigated the following three research questions: (a) How are RC IMs distributed along the APES levels in a sample of EFT for depression?; (b) Are there differences between groups in the APES levels of RC IMs of good and poor outcome cases?; and (c) Are there differences in the APES levels of RC IMs appearing in distinct EFT phases (initial, middle and final)?

3. METHOD

3.1. Participants

Clients. The six clients were participants in the York I depression study (Greenberg & Watson, 1998) that compared the efficacy of client-centered therapy (CCT) and emotion-focused therapy (EFT) in the treatment of depression. These six cases were randomly assigned to EFT and then completely transcribed to allow for intensive process research (these cases have also been used in previous studies under the Assimilation model and the Innovative Moments model; e.g., Brinegar, et al., 2006; Cunha, et al., in press; M. Gonçalves, Mendes, et al., 2010; Honos-Webb, Stiles, Greenberg & Goldman, 1998; Honos-Webb, Stiles & Greenberg, 2003; Mendes, et al., 2010; Mendes, et al., 2011). These clients attended 15 to 20 EFT sessions (M=17.50, SD=1.98) and all met diagnostic criteria for major depression, according to the DSM-III-R (4 female, 2 male; 5 married, 1 divorced; all Caucasian). Ages ranged from 27 to 63 years old (M = 45.50, SD = 13.78).

Therapists. These six cases involved five therapists (4 female, 1 male; 4 Caucasian, 1 Indian), with diverse levels of education (from advanced doctoral students to PhD level clinical psychologists). All of them had participated in a 24-week training in EFT using the manual for the York 1 depression study (Greenberg, Rice & Elliott, 1993), which included eight weeks for CCT, six weeks for systematic evocative unfolding, six weeks for two-chair dialogue, and four weeks for empty-chair dialogue training.

Researchers. The IMs were coded in an earlier study (see Mendes, et al., 2010) by two judges (PhD students in their twenties; one female, one male). For this study, two other judges (PhD student, in her thirties, female; and an MA student in her twenties, MA student, female) coded the RC IMs according to the APES levels.

3.2. Treatment

EFT is a treatment modality that integrates the client-centered relationship conditions with process-directive experiential interventions (Greenberg, Rice & Elliott, 1993). This treatment draws its principles from emotion theory (Greenberg & Safran, 1989) and aims to transform maladaptive emotion processing through facilitating client's

emotional awareness and access to core organismic needs (Greenberg, 2002, 2006; Greenberg, Rice & Elliott, 1993; Greenberg & Watson, 2006). To achieve these goals, emotion-focused therapists act through the empathic attunement, unconditional positive regard, congruence and presence in the relationship, to provide a safe therapeutic environment. Moreover, in order to help clients process their emotional experience in the here-and-now, they also use process-directive interventions derived from other experiential approaches (like *Gestalt therapy* – Perls, Herline, & Goodman, 1951, and *Focusing* – Gendlin, 1981). This unique conjugation leads to a particular therapeutic style, called *active empathy* (Greenberg, 2006) that balances between following the client (client-centered relationship stance) and leading the client (guiding clients' attention to their emotional processing during the experiential tasks). Therapist guidance is particularly visible after the detection of certain process markers in the client, which direct to task unfolding (e.g., self-critical splits lead to two-chair exercises; unfinished business to empty-chair work, among others; Elliot, Watson, Goldman, & Greenberg, 2004; Greenberg, 2004, 2006; Greenberg, Rice & Elliott, 1993; Greenberg & Watson, 2006).

3.3. Measures

Innovative Moments Coding System (IMCS). The Innovative Moments Coding System includes 5 mutually exclusive categories of IMs: action, reflection, protest, reconceptualization and performing change. In terms of inter-judge agreement, Matos et al. (2009), reported 86% agreement on IM salience (proportion of words occupied by all IMs in a session divided by the number of words of that session) and a kappa of .89 between 2 judges in the categorization of IMs' types. For the IMs' codings used in the present study, Mendes et al. (2010) reported 89% agreement on salience and a kappa of .86 between 2 judges for IM types, indicative of strong agreement (Hill & Lambert, 2004).

Assimilation of Problematic Experiences Sequence (APES). Assimilation analysis (Stiles, 1999, 2001) generally follows a constructivist research paradigm (Ponterotto, 2005) involving a four-step procedure that requires: 1) familiarization and cataloguing; 2) defining themes across therapy; 3) excerpting; and 4) applying the APES

(see Honos-Webb, et al., 1998, for a detailed description). In this method usually one or two primary judges conduct each one of the steps, arriving at a primary qualitative analysis. The process and analysis are then discussed with consultants (either experts in the use of assimilation analysis or experts in the therapy process under investigation) that serve as auditors, reviewing transcripts, APES codings and preliminary findings. Divergent interpretations are discussed and in some cases changed through a process of consensual discussion. The goals can be to arrive at a more global formulation of the case (see Honos-Webb, et al., 1998) or a microanalytic coding of segments of therapy dialogue (see Caro-Gabalda, 2005, 2008).

3.4. Procedures

Case selection and coding of the IMCS. In the previous study by Mendes and colleagues (2010) three cases represented good outcome (Lisa, Sarah and Jan – fictional names adopted by Honos-Webb, et al., 1998; Honos-Webb, Stiles & Greenberg, 2003; and Honos-Webb, et al., 1999) and three cases represented poor outcome (George, Helen and Ralph, also fictional names), according to the pre and post treatment analysis of the reliable change index (see Jacobson & Truax, 1991; McGlinchey, Atkins, & Jacobson, 2002) of the Beck Depression Inventory (Beck, Steer, & Garbin, 1988; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). We used the cutoff of 14.29 and the RCI of 8.46 proposed by Seggar, Lambert, and Hansen (2002). Pre to post BDI scores for the good outcome cases were 25 to 3, 30 to 5, and 35 to 4 (M = 30.00, SD = 5.00 for pre-test; M = 4.00, SD = 1.00 for post-test), and for the poor outcome cases was 15 to 13, 23 to 22, and 24 to 18 (M = 20.67, SD = 4.93 for pre-test; M = 17.67, SD = 4.51 for post-test). Mendes et al. (2010) carried out the codings according to the IMCS.

Coding of the APES. For the present study, we followed the procedures of the assimilation analysis conducted by Caro-Gabalda (2005, 2008), involving the following three steps: familiarization, cataloguing and the analysis of excerpts (i.e. RC IMs) with the APES.

Familiarization. For each case, both judges independently read the first two sessions of a case and then met to discuss the client's presenting problems and case

evolution (summarized by the first author given the information available by published case studies, though not revealing outcome status to the second judge).

Cataloguing. All sessions with reconceptualization IMs were selected for further analysis (according to the codings carried out by Mendes, et al., 2010), having the IMs highlighted for further coding with the APES.

Consensual analysis of APES levels. At this stage and in line with the procedures of *consensual qualitative research* (Hill, et al., 2005; Hill, Thompson, & Williams, 1997), each judge independently read the complete session and coded the RC IMs according to the APES. For this, the judges were guided by two questions: a) Which is the most appropriate APES level for this narrative as a whole? and b) Which problematic themes appear? Sessions were coded two by two and then followed by a meeting were the judges discussed codings, expressing and justifying their views and arriving at consensus judgments in face of divergent perspectives. The codings were then presented to a group of other PhD students, leaded by a senior researcher (last author), who audited the process. Only the first judge was aware of the outcome status of each case during the analysis of the APES.

To allow analyses from different therapy phases, the sessions were divided into three categories: the initial phase accounted for the first 4 sessions of each case; the final phase accounted for the last 4 sessions of each case and the middle phase accounted for all the sessions in between (corresponding to a *working-through* phase of EFT).

4. RESULTS

4.1. Overall findings

The six cases had 108 reconceptualization IMs (RC IMs). Each of these IMs had a mean salience of 4.82 each (SD=3.97; minimum of 0.40 and maximum of 21.49). The salience of reconceptualization in a session (total sum of the salience of all RC IMs in a session) had a mean of 12.48 (SD=13.22; minimum of 0.97 and maximum of 47.60).

Figure IV.2 displays the evolution of RC IMs' salience presented in the good outcome (GO) group and table IV.3 presents the salience of RC IMs appearing in the poor outcome (PO) groups (since there are only 7 RC IMs in the PO group and their

salience is very low, they are not depicted in a figure). The GO group exhibits an increasing trend of RC IMs' salience.

Figure IV. 2: Evolution of salience of reconceptualization IMs along therapy sessions of good outcome cases

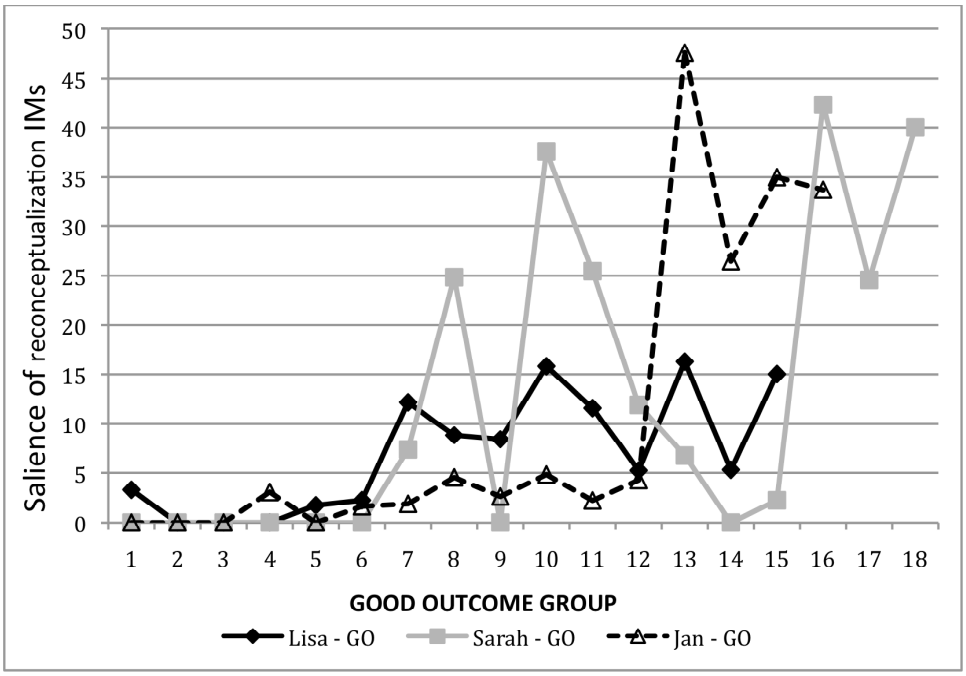


Table IV. 3: Salience of reconceptualization IMs in poor outcome cases

Poor Outcome Cases	Salience of RC IM	Session/Phase
George	6,99	6 (Working through)
	1,33	13 (Working through)
	4,03	17 (Final phase)
Helen	3,17	14 (Working through)
	1,89	16 (Final phase)
	0,97	20 (Final phase)
Ralph	2,39	15 (Final phase)

4.2. Distribution and illustration of reconceptualization IMs along the APES

The analysis with the APES showed that RC IMs were typically assessed with levels 4 to 6 (table IV.4). Globally, RC IMs had a median APES' level of 5 (mode=6) and the APES 4 to 6 level interval accounted for 88.0% (n=95) of the RC IMs in the six cases. Findings showed that the APES levels attributed to RC IMs had a minimum of 1 and a maximum of 7.

Table IV. 4: Distribution of APES levels assigned to reconceptualization IMs

APES LEVELS	PERCENT/FREQUENCY		
	COMPLETE SAMPLE	GOOD OUTCOME CASES	POOR OUTCOME CASES
1 – Unwanted thoughts	0,9% (n=1)	--	0,9% (n=1)
2 – Vague awareness/ Emergence	2,8% (n=3)	0,9% (n=1)	1,9% (n=2)
3 – Problem statement/ Clarification	4,6% (n=5)	4,6% (n=5)	--
4 – Understanding/ Insight	21,3% (n=23)	18,5% (n=20)	2,8% (n=3)
5 – Working through	31,5% (n=34)	30,6% (n=33)	0,9% (n=1)
6 – Problem solution	35,2% (n=38)	35,2% (n=38)	--
7 – Mastery	3,7% (n=4)	3,7% (n=4)	--
TOTAL	100% (N=108)	93,5% (n=101)	6,6% (n=7)

To account for this heterogeneity of RC IMs in light of the different APES ratings attributed to them, an example for each level is presented below. The criterion for selecting these examples was excerpt length (we restricted to the smaller excerpts to provide an effective illustration within the space constraints).

APES level 1. In the following RC IM from session 17, George was talking about how his father (who had died some years ago) had never been capable of showing a direct appreciation towards him, although a family member had told him that he heard him saying he was proud of his sun George. Throughout therapy, George expressed resentment for not having had a closer relationship with both his parents and for struggling with his financial security after being out of his father's will (in contrary to his

other brothers). The contrast in the self emerged from the clients' expression that the relationship with his father was no longer an important issue, since nothing could be done anymore to change it. This RC IM was coded with APES level 1 – unwanted thoughts – due to the following client processes: a) George attempted to disengage from his negative feelings still lingering toward his father; b) the client did not comply with his therapist whenever he tried to talk with him about his feelings and unmet needs; and c) preferred not to elaborate on the issue of their relationship.

> *George:* [Replying about how he feels when talking about his father's lack of appreciation] *Quite detached as a matter of fact, quite detached, um*
>
> *Therapist (T): I don't know, I mean I have a sense that there's some anger there, well dammit, you know, I needed it and he*
>
> *George: I think I've worked through it enough to uh, in his case, I think, that it's not a factor anymore, and if it is well it's not a very big factor*
>
> *T: But I suppose if it was a factor, it might make you feel kind of sad, I mean that he told it to somebody else* [that he was proud of his sun George]
>
> *George: It's a dead issue really in more ways that one, because the other two players, the other three players are all dead now, he and my stepmother and my stepbrother, they're all dead, and (T. nothing can be done about that) it's basically a shut case, lost opportunity or whatever you want to call it*

APES level 2. In the following RC IM from session 4, Jan started to make sense of her symptoms (the hives) as a way that her body had to communicate that something was wrong in her life, while in the past the hives would just be incomprehensible and an intense source of distress. This RC IM was coded with APES level 2 – vague awareness/emergence – due to the following client processes: a) the bodily symptoms (hives) appeared intermittently; b) here, the client started realizing that her physical

symptoms may have psychological meaning; and c) the client was still not able to grasp its significance and relate it with a clear problem formulation (i.e. overburdening herself and putting other people's needs first):

Jan: I think that's a trigger point (T: yeah) I think I've accepted it that the hives are something that subconsciously my body is telling me that I have to do something, make some changes (T: mm-hm) you know, whichever they are

T: That's sending you a message

Jan: Mm-hm. I just have to listen to it and not ignore it like I have in the past

T: Mm-hm. So it's kind of an important sign that something's going on

Jan: Yeah, I think that's the only thing, really the hives are the only thing that's really triggering it for me, because it's visual

T: Mm-hm, so you can really see that something's going on

Jan: Mm-hm. I can't ignore it as much as (T: mm-hm) you know, I can ignore a headache or a pain in my neck or something like that

APES level 3. In the following RC IM from session 1, Lisa talked about the relationship with her husband and how his gambling habit and disengagement from family life was a substantial source of disturbance in her life. Contrast in the self appeared as she talked about herself no longer trying to change her husband (as she did unsuccessfully in the past) and that she should concentrate on working on herself instead. This RC IM was coded with APES level 3 – problem statement/clarification – due to the following client processes: a) Lisa defined a focus for therapy (working on herself and how she felt); b) affect is negative but not disruptive.

Lisa: And I believe that, you know, he [husband] *can be helped but he doesn't see it or he doesn't want it and I've stopped changing him, I don't want to change him anymore, because you know, I'm just looking at my own problems*

T: Uh huh, so rather than say, trying to control his behavior, it's more like

Lisa: Right, I don't do that anymore, I don't do that as much as I used to (T: Uh-huh) I just

T: You just focus on yourself and what you feel

Lisa: Yeah myself and what's happening at that moment (T: mm-hm)

APES level 4. The following RC IM was drawn from session 9 with Jan. In the context of a self-evaluation conflict split, Jan realized that she was overburdened with the attempt to take care of everything and everyone, always being too critical with herself and a perfectionist. She understood now the need to accept herself when doing the best she could do, and to be more understanding with her own flaws and limitations. This RC IM was coded with APES level 4 – understanding/insight – since it illustrated the following client processes: a) taking a step back, through self-reflection, to take a better look on the problem (i.e. acting as if she was a superwoman, always caring for other people' needs and whishes first); b) increasing insight and further understanding the problem and current difficulties; and c) becoming aware of how her past was influential to her present. This RC IM also presented some mixed affect, as Jan addressed her guilt and pain for not having been a better mother along with some self-acceptance that emerges with the softening of the self-critical voice.

Jan: [The client talks as the self-critic addressing the experiencing self] [sigh; sniff; another sigh] *I guess you can't ask for anymore than when somebody's thinking they are giving their best.*

T: Mm-hm. So what do you want to say to her?

Jan: [sigh; pause] *Maybe you're being too hard on yourself (T: Mm-hm) and you should allow yourself to be human. And you can make mistakes at times and be able to forgive yourself. And then maybe you could also, if you ask your son for forgiveness and he wants to give it to you, to accept it and go on from there and heal from that* [sniff].

T: Mm-hm. So it sounds like you kind of understand her, understand her a bit more why she did the best she could.

Jan: [sniff; sigh] *I guess it's a lot. Like, she thought her parents did the best under the circumstances and she doesn't hold any grudges against them for doing their best, even though it wasn't always*

T: So you understand she did her best?

Jan: I guess so.

T: Is there anything else [Client sniff] *you want to say to her? Anything more? Do you feel like she should have done any other things?*

Jan: [pause] *I think she should learn from that experience (T: Mm-hm).*

APES level 5. In this excerpt from session 11, Sarah talked about several decisions she had to make during the week and how she had to choose between competing activities (in the past, this would be regarded as a problematic experience). In this RC IM, the client presented a contrast with the past, given that the present difficulties were no longer seen as obstacles but rather as opportunities to exercise the recognition of her whishes and needs (formerly faced with intense self-doubt and confusion). This RC IM was coded with APES level 5 – working through – due to the following client processes: a) Sarah's current understanding on the problem was used to approach current difficulties in a new, productive way; b) the client expressed the decision to act differently in the present; and c) showed an optimistic attitude towards present difficulties. Even though the attempts to solve the problem were not yet completely successful, they no longer dishearten the client.

Sarah: Yeah because it kind of helps me to figure out what's really important to me and sometimes everything seems to be important but, yeah, that's when I kind of get really frustrated. Like I just can't get away from yesterday trying to rearrange things. But, I don't know, I guess that has also been something with my background that you are on time and, no matter what, you make it for the appointment. (T: mm-hm) And sometimes, even if you do

have a good explanation for it because things just didn't work out, even that didn't matter – you were just guilty.

T: So you feel like that, yeah.

Sarah: But it's good that this is happening right now because it kind of readjusts things for myself. Like, this is what happened back then (T: hm) and I don't have to carry this way of thinking with me.

T: Mm-hm, so you're trying to get away from that feeling?

Sarah: Oh yes, yeah, definitely.

APES level 6. In the following RC IM from the beginning of session 14, Lisa talked about having been able to overcome some of the anger that she felt towards her husband due to his gambling problem and their relationship. This transformation was possible because of new social support (e.g. church community) and therapy. This RC IM was coded with APES level 6 – problem solution – due to the following client processes: a) successful ways of coping with the problem and finding solutions; b) feeling proud and satisfied with the changes achieved; and c) positive affect towards herself (e.g. increased empowerment).

Lisa: And just overcoming those feelings that I had [anger toward her husband] *(T: yeah, yeah) way back, so that's been a help.*

T: That's been real progress for you.

Lisa: Oh yeah, yeah. And then again, like, I've also had the other support from the church so

T: That's helpful.

Lisa: Yeah, that's helpful. And I've been doing the marriage-counseling course. They had a marriage seminar that I did, and that's been really helpful too.

T: Has it?

Lisa: Yeah, yeah. So, you know, I'm getting feedback from other things too (T: right) and after a while you kind of put it all together (T: uh-huh). So, in that aspect, you know, I feel pretty comfortable.

T: So you're saying that it's like something has kind of shifted.

Lisa: Yeah, oh yeah, yeah. I feel that way and, you know, this has really done wonders for me, (T: uh-huh) it really has. I feel really comfortable with it (T: yeah) and it seems to

T: Comfortable with being here – is that what you're saying? Or you're comfortable with where you've gotten to?

Lisa: Yeah, where I've gotten to and what has been accomplished. That's comfortable, and being here too is being comfortable.

T: Yeah, but you really meant like

Lisa: What has occurred and what has come out.

T: So you feel that and you feel much more sort of sure or secure in yourself, is that it?

Lisa: Yeah, yeah, I feel secure. I guess I've accomplished something and um

T: Yeah, I'm just wondering about the shift.

Lisa: The shift, yeah. There's, there's a lot more security (T: mm-hm) um, I say security is being at peace, um just worth, being worth.

T: Being more worthy.

Lisa: [laugh] *Yeah, yeah, there's that in there (T: yeah) comfortable with, (T: mm-hm) with myself and who I am. So that's the shift that, the progress that I see.*

T: Yeah, the feeling inside.

Lisa: Yeah, yeah, the strength.

APES level 7. In the following RC IM from session 18, Sarah reflected about herself in the present in contrast to the usual way of functioning in the past. She also addressed the transformation processes that were crucial for the change process. Two processes appeared in the beginning of this reconceptualization: empathizing with herself and understanding her difficulties, allowed integration between heart and mind. This RC IM was coded with APES level 7 – mastery – due to the following client processes: a) the

acknowledgement of tools that were developed and can be used in the future and b) an increased sense of mastering difficulties when dealing with new, different challenges.

Sarah: Yeah, yeah that was, now I can say that was very important [reflecting on her past and how she felt growing up during the sessions]. *And just, like you said, empathizing with myself and well it was the only or, for me, the best way to cope with things.*

T: At the time?

Sarah: Yeah, at the time.

T: And you could see that sort of when you went back and really felt those feelings again, even just a little bit.

Sarah: Ooh, [laughs] *and just like* [pause] *also like getting a sense of… There's obviously the head thing and then the feeling or the heart thing. And, you know, there is just so much information out there and you can just like read forever. But it's different from reading it and from having the knowledge or the information in your head (T: Yeah, uh-huh.) and saying "Yeah, this makes sense". But once it happens, like not only do you have it in your head, but you really feel from your heart, or from my heart I guess (T: Yeah), merging the two almost* [laughs].

T: Yeah, it's not just some intellectual thing, it's something you really feel inside (Sarah: yeah). It feels right and something really moves or shifts and changes.

Sarah: Yeah, yeah. And there are always different events and different happenings in our life and we have to, I guess, I have my own coping mechanisms and I guess I got stuck in something. But I really made an effort to change and [laughs], *I don't know, put it in perspective. I guess the thing is that there isn't a right or a wrong. Just like getting a sense of – okay, now I know and I have a much better sense of myself and I have certain tools I don't want*

to forget [laughs]. *And I work with it and just use it, you know, continue to use it for myself.*

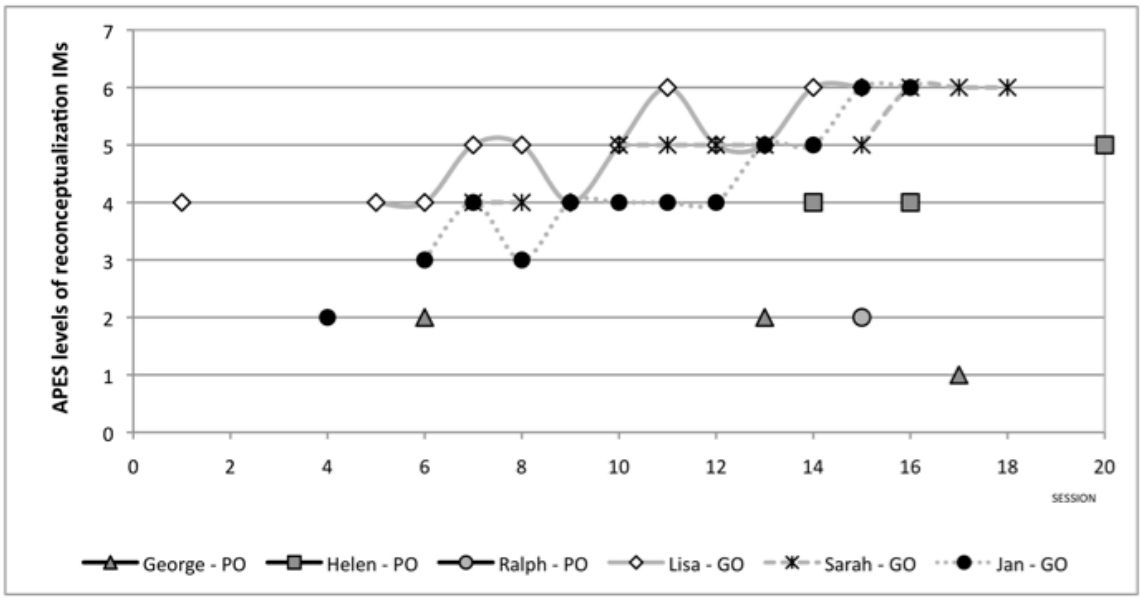
4.3. Are there differences between groups in the APES levels of RC IMs from good and poor outcome cases?

When accounting for different outcome groups, the median APES' level of the GO group was 5 (mode=6; minimum of 2 and maximum of 7), while for the poor outcome (PO) group it was 4 (mode= 4; minimum of 1 and maximum of 7). To test for differences between the median APES levels of GO and PO groups, we performed a Mann-Whitney test. Results showed that the APES ratings were higher for the GO group (*Mdn*=5) than for the PO group (*Mdn*=4), U=91.5, $p \leq 0.001$, r=2.5.

4.4. Are there differences in the APES levels of RC IMs appearing in distinct EFT phases?

Figure IV.3 shows the evolution of the median APES levels along the sessions of these six EFT cases.

Figure IV. 3: Evolution of median APES levels of reconceptualization IMs along therapy sessions of good and poor outcome cases



Taking into account the six cases (N= 108 RC IMs), we conducted a Kruskal-Wallis test to evaluate differences among the three therapy phases: initial (four beginning sessions), middle (all the sessions between the fifth and the one before the last four) and final (four last sessions of each case). The results of the analysis indicated that there was a statistically significant difference in the median APES ratings, χ^2 (2, N=108)=36.08, $p \leq 0.001$.

Because the overall test was significant, pairwise comparisons among the three groups were completed. Follow up tests were conducted to evaluate pairwise differences among the three groups, controlling for type I error across tests by using the Bonferroni correction. Results indicated that there were statistically significant differences in the median APES ratings between the initial and middle phases (U=25.0, $p \leq 0.01$, r=0.43), between the middle and final phases (U=385.0, $p \leq 0.001$, r=0.6) and also between the initial and final phases (U=13.5, $p \leq 0.001$, r=0.46). The APES ratings of RC IMs were higher in the final phase (*Mdn*=6) when compared to the initial phase (*Mdn*=3), U=13.5, $p \leq 0.001$, r=0.46 and to the middle phase (*Mdn*=5), U=385.0, $p \leq 0.001$, r=0.6. The APES ratings were also higher in the middle phase (*Mdn*=5) than the initial (*Mdn*=3). These results supported an increasing trend of APES ratings of RC IMs along the evolution of therapy.

The same analysis was conducted to explore for differences between therapy phases within each outcome group. In the GO group, the results of a Kruskal-Wallis test conducted to evaluate differences among the therapy phases of the GO group indicated that there was a statistically significant difference in the medians of APES ratings of this group, χ^2(2, N=101)=44.27, $p \leq 0.001$.

Pairwise comparisons among the three groups using the Bonferroni correction were also completed, because the overall test was significant. Results indicated that there were statistically significant differences between the initial and middle phases (U=25.0, $p \leq 0.01$, r=0.42), between the initial and final phases (U=2.0, $p \leq 0.001$, r=0.53) and also between the middle and final phases (U=385.0, $p \leq 0.001$, r=0.6). The APES ratings were lower in the initial phase (*Mdn*=3) than in the middle (*Mdn*=5) and final phase (*Mdn*=6) of therapy. And the ratings in the final phase (*Mdn*=6) were also higher than in the

middle phase (*Mdn*=5). These results for this group also supported an increasing trend of APES ratings of RC IMs along the evolution of GO therapy.

In the PO group, since there are no RC IMs emerging in the initial phase of this group, we performed a Mann-Whitney test to explore for differences between the middle and final phases of EFT. Results indicated that there were no significant differences in the APES ratings of RC IMs between the middle (*Mdn*=3) and the final therapy phases (*Mdn*=4) of this group, U=4.5, p=.857, r=2.83.

5. DISCUSSION

The present study explored the diversity and evolution of reconceptualization innovative moments (RC IMs) in a sample of EFT with depressed clients, through a systematic analysis of these IMs with the assimilation model. The findings show that RC IMs can vary quite a lot within the assimilation continuum, as some were coded with very low APES levels, such as 1 (unwanted thoughts/dissociated) or as high as 7 (integration/mastery). Despite this variety, only a small amount of RC IMs received ratings lower than APES level 4 (only 9% - we will elaborate on this result further below), while the majority of RC IMs (88%) was coded within the APES 4 to 6 levels interval. This means that the majority of RC IMs appearing in this sample involves complex assimilation processes such as: further understanding and insight about the problem (APES level 4 – 21%), attempts to work through the problematic experiences (APES level 5 – 32%) or using the problem as a new resource in the application of problem solving skills to address current challenging experiences (APES level 6 – 35%). The fact that the majority of RC IMs exhibit this range of highly assimilated processes is congruent with the previous literature in the field. As Matos et al. (2009, p. 10) put it:

> "It may also be noted that re-conceptualization IMs seem to converge (a) with the concept of insight in psychodynamic approaches; (b) with the concept of understanding/insight in the assimilation of problematic experiences sequence, which has similarly been differentially associated with favorable outcomes".

Therefore, such higher ratings were expected from the notion of reconceptualization: when talking about the transformation processes that explain the contrast in the self (the self in the past constrained within the problematic narrative in opposition to the different self-version in the present), clients elaborate on their recent achievements in their change trajectories, frequently present new understandings about the problem (Gonçalves, Matos & Santos, 2009), develop meaning bridges between the former and the current self (or between the problematic experience and the familiar community of voices – Brinegar, et al., 2006) and talk about how they start dealing with the problem differently.

As expected, the findings from the contrast between good (GO) and poor outcome (PO) groups show that the GO group achieves higher assimilation levels (median of 5) than the PO group (median of 4). The fact that the PO group in this sample attains a median level of 4 is inconsistent with the previous literature on the assimilation model (Caro-Gabalda, 2008; Detert et al., 2006; Honos-Webb et al., 1999; Stiles et al., 1992). The study by Detert and colleagues (2006) is particularly important for the discussion of these findings since it was the first to test and empirically confirm a central theoretical hypothesis of the assimilation model: GO cases are expected to reach an APES level equal or superior to 4 while PO cases are expected to remain in lower levels of assimilation. At first sight, their findings contrast with ours; however, several remarks need to be done here. First, our study only analyses RC IMs through the microanalytic coding of the APES for small therapy segments (e.g. Caro-Gabalda, 2005, 2008), instead of aiming for a global case-formulation, such as carried out in the study by Detert et al. (2006). RC IMs, since they represent a more complex type of innovative narratives, may score higher in the APES (even in PO cases) than if we were accounting for a more global clinical formulation of client problems. Second, the study of Detert et al. (2006) focused on eight cases of very brief psychotherapy (two sessions plus a follow-up of cognitive-behavioral therapy or psychodynamic-interpersonal therapy), while in this study the number of EFT sessions each client received ranged from 15 to 20. Therefore, it is reasonable to expect that a longer treatment may provide further gains in the assimilation of problematic experiences. Furthermore, these three PO cases also showed

some improvement (evidenced by a mean decrease in post-treatment BSI), even though symptoms did not drop to a non-clinical level (i.e. PO clients remained clinically depressed). This improvement may be related to brief and episodic gains in insight that are captured within some of the few RC IMs appearing in these PO cases. Third, we use the median of the APES levels to explore for differences in the contrast between outcome groups while Detert et al. (2006) used the mean APES levels, given that they rated the subscales within the APES.

Another interesting finding provided by this study relates to the differences observed in RC IMs emerging in different therapy phases. As treatment develops, RC IMs evidence a clear increasing trend in the assimilation of problematic experiences: in the initial phase of EFT, the median APES of RC IMs was 3; in the middle (working-through) phase, the median APES was 5; and in the final phase it was 6 (these results remain the same when taking into account the global sample of 6 cases or only the 3 GO cases). This is convergent with prior studies on the assimilation model (Caro-Gabalda, 2008; Detert et al., 2006; Honos-Webb et al., 1999; Stiles et al., 1992) and provides some empirical support to the hypothesis raised by Cunha et al. (in press) that recursivity of reconceptualization during therapy seems important to consolidate therapeutic gains and allow self-narrative change (see also Cunha, Gonçalves & Valsiner, 2011).

As expected, this progression in the APES was not replicated in the PO cases. In fact, in the case of George (contrary to the case of Helen, which showed some gain along the APES towards the final EFT phase), the last RC IMs exhibited an extremely low degree of assimilation (APES level of 1 – illustrative excerpt above), which represented a decrease regarding the other two previous RC IMs. This is consistent with prior analysis of this case, carried out by Honos-Webb, et al. (1998) that found a setback in how George dealt with his "rageful longings for his father, which progressed from unwanted thoughts to vague awareness briefly but seemed to fall back to unwanted thoughts again" (p.277).

6. IMPLICATIONS AND LIMITATIONS

This study clearly suggests that RC IMs and the assimilation of problematic experiences are distinct constructs (shown by the heterogeneity of RC IMs distributed

along the APES), even though sharing some overlapping features (in most of RC IMs which are rated in higher APES levels). This difference between reconceptualization and assimilation introduces an interesting possibility: to combine their use in order to produce a better prediction of good outcome. Future studies could explore the effects of the combination of these two models, for example, through process-outcome designs (Elliott, 2010). Previous studies showed that high levels of assimilation are associated with GO therapy (Caro-Gabalda, 2008; Detert et al., 2006; Honos-Webb et al., 1999; Stiles et al., 1992), while other studies showed that higher salience of RC IMs is also associated with GO therapy (Alves, et al., in press; Gonçalves, Mendes, et al., 2011; Matos, et al., 2009; Mendes et al., 2010). The present study complements the last, indicating that GO cases are distinguished from PO cases not only by the salience of RC IMs, but also by their level of assimilation. In other words, this study suggests that the assimilation model may be used as a tool to distinguish the quality or productivity of RC IMs (i.e. as an external validity measure – Campbell, 1986), at least in EFT. Hence, future studies may address the specific features of "high quality" RC IMs in order to systematize how these can be facilitated in EFT (for example, through task analysis – Greenberg, 2007).

Finally, this study has some limitations. It focuses only on six cases, and especially the PO group has very few RC IMs. Therefore, the conclusions drawn here must be regarded as exploratory, and future studies should enlarge this sample, in order to facilitate generalization. At the same time, these conclusions are only related with EFT. This model is clearly focused in working with painful emotional experiences, and the process of assimilation seems quite suited to this therapeutic model, as previous studies have argued (Honos-Webb et al., 1998). It is important to verify if these findings replicate with other kinds of psychotherapy, particularly those that depart from clearly distinct assumptions (e.g., cognitive-behavioral therapies).

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CHAPTER V

NARRATIVE REORGANIZATION IN EMOTION-FOCUSED THERAPY: A PRELIMINARY TASK ANALYSIS

CHAPTER V

NARRATIVE REORGANIZATION IN EMOTION-FOCUSED THERAPY: A PRELIMINARY TASK ANALYSIS[10]

1. ABSTRACT

This study explored through the method of task analysis method how client-therapist dyads in emotion-focused therapy (EFT) depart from problem exploration and arrive at a narrative reorganization of the self. Using the repetition of reconceptualization innovative moments (IMs) and its articulation with performing change IMs to locate this in-session process, a rational model was built and then revised in the contrast with real performances from a sample of three good outcome dyads of EFT for depression. This preliminary study presents the rational model and the revised rational-empirical model of narrative reorganization in EFT, which discovered nine steps necessary for successful task completion: 1) Explicit recognition of differences in the present and steps in the path of change; 2) Emergence of a meta-perspective contrast between present self and past self; 3) Amplification of contrast in the self; 4) Positive appreciation of changes; 5) Feelings of empowerment, competence and mastery, accompanied by therapist validation; 6) Reference or exploration of difficulties still present; 7) Loss of centrality of the problem; 8) Change as a gradual, developing process; and 9) New plans, projects or experiences of change. Central aspects of therapist activity in facilitating the client's progression in this process are also elaborated.

2. INTRODUCTION TO STUDY 5

A growing number of researchers have highlighted that the elaboration of narrative novelties is an important aspect of change, not only specific to narrative therapy but also in other therapeutic modalities (Angus & McLeod, 2004; Angus & Rennie, 1989; Boritz, et al., 2011; Gonçalves, Ribeiro, et al., in press; Gonçalves & Stiles, 2011;

[10] This paper has the following authors: Carla Cunha, Miguel M. Gonçalves, Inês Mendes, Jaan Valsiner, António P. Ribeiro, Lynne Angus, and Leslie Greenberg.

Mendes et al., 2010, 2011). According to this view, the narrative reorganization of the self during psychotherapy is achieved through a new sense of agency and a renewal of authorship, that facilitates the integration of recently acquired (emotional, cognitive and/or behavioral) changes of the individual in a new self-narrative (Adler, Skalina, & McAdams, 2008). In this study, we present a model that displays the necessary steps for achieving the narrative reorganization of the self in emotion-focused therapy, derived from the method of task analysis (Angus & Greenberg, 2011; Greenberg, 2007; A. Pascual-Leone, Greenberg, & J. Pascual-Leone, 2009).

2.1. Narrative change in emotion-focused therapy

According to the narrative perspective of psychotherapy (e.g., Angus & McLeod, 2004; Avdi & Georgaca, 2007; Gonçalves & Stiles, 2011; White, 2007; White & Epston, 1990), clients seek help when they feel constrained by problematic self-narratives that evidence problems and personal deficits (Angus & Greenberg, 2011; Boritz, et al., 2008, 2011; Botella, et al., 2004; Dimaggio & Semerari, 2004; Salvatore, Dimaggio & Semerari, 2004). Therefore, the elaboration of new stories and narrative novelties in psychotherapy has been conceptualized as a powerful tool to break the dominance of problems and facilitate self-transformation (Angus & McLeod, 2004; Gonçalves, Matos, & Santos, 2009; Gonçalves & Stiles, 2011; Levitt, Korman & Angus, 2000; White & Epston, 1990).

More specifically, in emotion-focused therapy (EFT), the articulation of significant personal events into meaningful stories and the subsequent narrative change (Angus, et al., 2004; Greenberg & Angus, 2004) has been linked with emotion transformation during treatment (Missirlian, et al., 2005) and changes in autobiographical memory in depression (Boritz et al., 2008, 2011). These studies led Angus and Greenberg (2011) to propose recently that successful EFT processes evolve around four phases: 1) Promoting dyadic bonding, narrative unfolding of significant personal experiences and experiential awareness; 2) Supporting emotional evocation/exploration and the articulation of core emotion-schematic memories and themes; 3) Transforming maladaptive into adaptive emotions and developing new story outcomes; and, finally, 4) Facilitating the consolidation of changes and the narrative reorganization of the self.

2.2. Innovative Moments Coding System

Within the narrative approach to psychotherapy, the Innovative Moments research group (Gonçalves, Ribeiro, et al., 2011) has been studying which exceptions (that is, innovative moments) to the problematic patterns that brought clients to therapy occur in different therapeutic modalities and characterizing how they lead to therapeutic change. The concept of innovative moments (hereby IMs) refers to different kinds of novelties, new experiences, actions and thoughts that emerge in the therapeutic conversation and that contrast with the problematic self-narratives initially presented in treatment. Five types of IMs have been observed and reliably identified with the Innovative Moments Coding System (IMCS – described in table V.1): action, reflection, protest, reconceptualization, and performing change (Gonçalves, Matos, & Santos, 2009; Gonçalves, Ribeiro, et al., 2011).

Previous research has shown that more IMs occur in good than poor outcome cases across several samples of therapy (narrative therapy – Matos, et al., 2009; emotion-focused therapy – Mendes et al., 2010; client-centered therapy – Gonçalves, Mendes, et al., 2011). These studies provided evidence for the validity of this construct as an indicator of change across different therapeutic modalities and client problems. Yet, only reconceptualization IMs clearly distinguish good from poor outcome therapy, with consistent results replicated across samples (Alves et al., 2011; Gonçalves, Mendes, et al., 2011; Matos, et al., 2009; Mendes et al., 2010).

Two main arguments have been presented to support the importance of reconceptualization in the evolution of therapeutic change. On the one hand, reconceptualization implies a meta-perspective upon the self and heightened metacognitive abilities, usually favorable to therapeutic outcome (see also Carcione et al., 2008; Cunha, et al., in press; Gonçalves, Matos & Santos, 2009; Gonçalves & Ribeiro, in press; Semerari et al., 2007). On the other hand, it implies a new position of authorship over the process of change, given that the client recognizes, understands and articulates differences in the self (Cunha et al., in press; Gonçalves et al., 2009; Gonçalves & Ribeiro, in press; Matos et al., 2009; Mendes et al., 2010). These features of

reconceptualization seem to be crucial for the facilitation of a narrative reorganization of the self in psychotherapy.

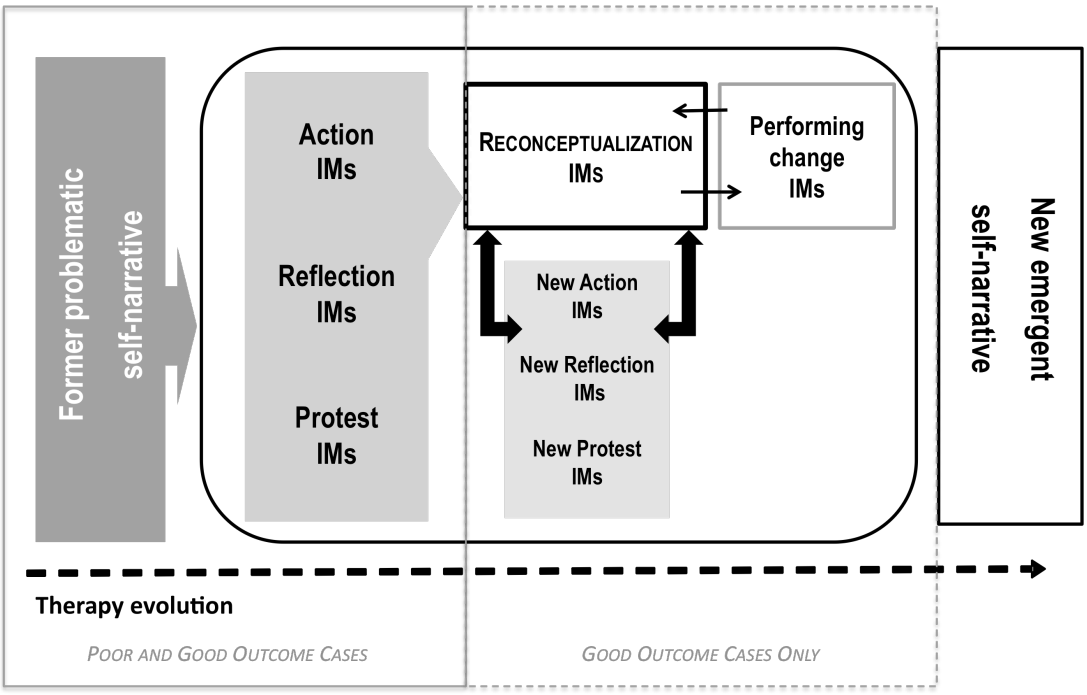
Table V.1: The Innovative Moments Coding System

(Gonçalves et al., 2010)

Types of Innovative Moments	**Examples** (Problematic narrative: depression)
ACTION IMS	
Action IMs refer to events or episodes when the person acted in a way that is contrary to the problematic self-narrative.	*C: Yesterday, I went to the cinema for the first time in months!*
REFLECTION IMS	
Reflection IMs refer to new understandings or thoughts that undermine the dominance of the problematic self-narrative. They can involve a cognitive challenge to the problem or cultural norms and practices that sustain it or new insights and understandings about the problem or problem supporters. These IMs frequently can also assume the form of new perspectives or insights upon the self while relating to the problem, which contradict the problematic self-narrative.	*C: I realize that what I was doing was just, not humanly possible because I was pushing myself and I never allowed myself any free time, uh, to myself ... and it's more natural and more healthy to let some of these extra activities go…*
PROTEST IMS	
Protest IMs involve moments of critique, confrontation or antagonism towards the problem and its specifications and implications or people that support it. They can be directed at others or at the self. Oppositions of this sort can either take the form of actions (achieved or planned), thoughts or emotions, but necessarily imply an active form of resistance, repositioning the client in a more proactive confrontation to the problem (which does not happen in the previous action and reflection IMs). Thus, this type of IMs entails two positions in the self: one that supports the problematic self-narrative and another that challenges it. These IMs are coded when the second position acquires more power than the first.	*C: I am an adult and I am responsible for my life, and, and, I want to acknowledge these feelings and I´m going to let them out! I want to experience life, I want to grow and it feels good to be in charge of my own life. I am not going to put up with this anymore!*
RECONCEPTUALIZATION IMS	
Reconceptualization IMs always involve two dimensions: a) a description of the shift between two positions (past and present) and b) the transformation process that underlies this shift. In this type of IMs there is the recognition of a contrast between the past and the present in terms of change, and also the ability to describe the processes that lead to that transformation. In other words, not only is the client capable of noticing something new, but also capable of recognizing oneself as different when compared to the past due to a transformation process that happened in between.	*C: You know… when I was there at the museum, I thought to myself: you really are different… A year ago you wouldn't be able to go to the supermarket! Ever since I started going out, I started feeling less depressed… it is also related to our conversations and changing jobs…* *T: How did you have this idea of going to the museum?* *C: I called my dad and told him: we're going out today!* *T: This is new, isn't it?* *C: Yes, it's like I tell you… I sense that I'm different…*
PERFORMING CHANGE IMS	
Performing change IMs refer to new aims, projects, activities or experiences (anticipated or already acted) that become possible because of the acquired changes. Clients may apply new abilities and resources to daily life or retrieve old plans or intentions postponed due to the dominance of the problem.	*T: You seem to have so many projects for the future now!* *C: Yes, you're right. I want to do all the things that were impossible for me to do while I was dominated by depression. I want to work again and to have the time to enjoy my life with my children. I want to have friends again. The loss of all the friendships of the past is something that still hurts me really deeply. I want to have friends again, to have people to talk to, to share experiences and to feel the complicity in my life again.*

Drawing together these findings, Gonçalves and colleagues (Gonçalves, Mendes, et al., 2011; Matos, et al., 2009; Mendes et al., 2010, 2011) proposed a heuristic model of change in brief psychotherapy, which depicts the evolution of IMs in successful therapy (figure V.1).

Figure V. 1: A heuristic model of narrative change in psychotherapy from the Innovative Moments' perspective (Adapted from Gonçalves, et al., 2010)



In the beginning of treatment, action, reflection and protest IMs are the initial forms of innovation that occur in both good and poor outcome cases. However, during the middle phase of good outcome therapy, reconceptualization IMs tend to appear and become more frequent as therapy evolves and clients spend more time talking about them, becoming the dominant type until the end. The emergence of reconceptualization IMs and its increasing duration until the end of therapy seems to be the distinguishing feature of good outcome cases (Alves et al., 2011; Gonçalves et al., 2010; Gonçalves, Mendes, et al., 2011; Matos et al., 2009; Mendes et al., 2010, 2011). After the emergence of reconceptualization in the middle phase of therapy, performing change IMs appear expanding changes into the future. As reconceptualization and performing change IMs

are developed, new action, reflection and protest IMs also emerge within the same theme, feeding new cycles of reconceptualization and performing change IMs. These repetitive cycles of reconceptualization IMs, along with performing change IMs, represent a consolidation of narrative change and the achievement of a narrative reorganization of the self. This narrative process evidences the new way that clients have for experiencing themselves, the world and relationships with others, also anticipating and projecting new experiences of change into the future (Gonçalves, Matos & Santos, 2009; Gonçalves, Mendes, et al., 2011).

2.3. Current study: A task analysis of narrative reorganization in emotion-focused therapy

The task analysis of significant in-session change events, a method pioneered by Greenberg (1984, 2007) and refined with several colleagues (Greenberg & Foester, 1996; A. Pascual-Leone, Greenberg & J. Pascual-Leone, 2009) has been an important method to study significant change processes and key moments in psychotherapy (Elliott, 2010; Greenberg, 1991; Rice & Greenberg, 1984). Its application to the study of significant change events has helped to highlight client change processes involved in the successful resolution of several therapeutic tasks, such as unfinished business (Greenberg & Malcolm, 2002; Paivio & Greenberg, 1995), creation of meaning (Clarke, 1989, 1996) and emotional processing events (Pascual-Leone & Greenberg, 2007) in EFT. Furthermore, task analysis has also helped to differentiate productive therapist-client dyadic activity for the resolution of in-session ruptures in the therapeutic alliance during integrative psychotherapy (Safran & Muran, 1996), psychodynamic-interpersonal psychotherapy (Agnew, et al., 1994) and also alliance-threatening transference enactments in cognitive-analytic therapy (Bennett, Parry & Ryle, 2006).

According to several intensive case studies and a recent qualitative analysis of post-therapy change interviews (Angus & Greenberg, 2011; Kagan & Angus, 2010), the narrative reorganization of the self occurs at a final phase of EFT. The present study aims to contribute to the understanding of narrative reorganization of the self as a specific task to be accomplished in EFT, through the method of task analysis. The process of narrative reorganization will be operationalized here through considering the role that

reconceptualization IMs play in the evolution of narrative change in psychotherapy, given the previous studies conducted with the IMCS (revised above). That is, through the use of the IMCS, we equate the process of narrative reorganization of the self with the consolidation of reconceptualization in psychotherapy – i.e. the emergence of reconceptualization IMs and its repetition (or, alternatively, the subsequent emergence of performing change IMs after reconceptualization) within a same conversational theme.

Our goal here is to detail the necessary steps to successfully achieve the narrative reorganization of the self, presenting a preliminary (rational-empirical) model of client process and therapist activity. We hope to contribute to the understanding of this task by providing a moment-by-moment description of this particular client process and specific guidelines to help therapists facilitate it. Thus, by focusing on the in-session process of the narrative reorganization of the self, this study will address the following questions: How do client and therapist depart from the exploration of a problem and arrive at the narrative reorganization of the client' self? Which steps can EFT therapists take to facilitate the client's narrative change?

3. METHOD

3.1. Participants

Clients. The six cases used were drawn from the EFT condition of the York I depression study (Greenberg & Watson, 1998), where each client was randomly assigned to a brief EFT or client-centered therapy (15 to 20 weekly sessions). This sample includes 3 good and 3 poor outcome cases, transcribed to allow for intensive qualitative studies (e.g., Gonçalves, Ribeiro, et al., 2010; Honos-Webb, et al., 1999; Honos-Webb, Stiles & Greenberg, 2003; Mendes et al., 2010, 2011). All six clients (4 female, 2 males; 5 married, 1 divorced; all Caucasian) were clinically depressed (according to diagnostic criteria of the DSM-III-R) and completed an average of 17.50 (SD = 1.87) sessions of EFT. Their ages ranged from 27 to 63 years old (M = 45.50, SD = 13.78).

Outcome was classified based on a reliable change index analysis (Jacobson & Truax, 1991) of pre to post-treatment Beck Depression Inventory scores (BDI – a 21-item self-report inventory of depressive symptoms; Beck, Steer, & Garbin, 1988; Beck, et al.,

1961). The average BDI scores of good outcome cases decreased from 30.00 (SD = 5.00) in pre-treatment to 4.00 (SD = 1.00) in post-treatment and in poor outcome decreased from 20.67 (SD = 4.93) to 17.67 (SD = 4.51).

Therapists. These six cases involved five therapists (4 female, 1 male; 4 Caucasian, 1 Indian) with diverse levels of education (from advanced doctoral students to PhD level clinical psychologists). All participated in a 24-week training in EFT using the manual for the York 1 depression study (Greenberg, Rice & Elliott, 1993). This training included eight weeks for CCT, six weeks for systematic evocative unfolding, six weeks for two-chair dialogue, and four weeks for empty-chair dialogue training.

Researchers. This study involved three researchers that worked on qualitative data analysis (the first author, a PhD female student; the third author, a PhD female researcher and a MA female student) and a senior researcher acting as an auditor (second author, PhD male researcher). All researchers were Portuguese (English speakers as a second language) and familiarized with the cases. Two judges (the third and the fifth authors) had coded the six cases previously with the Innovative Moments Coding System (Mendes et al., 2010) and another two judges (the first author and a MA female student) coded the same cases using the APES (Assimilation of Problematic Experiences Sequence; Stiles, 1999; 2001; see further details in Cunha, Martins, et al., 2011).

3.2. Treatment

EFT intends to facilitate the client's process of experiencing and exploration of core organismic needs, leading to the transformation of maladaptive emotions into more adaptive ones (Greenberg, 2004, 2006; Greenberg, Rice & Elliott, 1993; Greenberg & Watson, 2005). This is accomplished by the integration of the client-centered relationship stance (congruence, unconditional positive regard and empathic attunement with the client) with process directive interventions, derived from other experiential therapies (e.g., *Gestalt* – Perls, Herline, & Goodman, 1951, and *Focusing* – Gendlin, 1981). This means that the EFT therapist balances between following the client (through the client-centered relationship stance) and leading the client (guiding the client's attention to further processing of emotional experience in the here-and-now through "active empathy"; Greenberg, 2006). Therapist guidance is particularly visible after the detection

of certain process markers in the client (such as problematic reactions, self-critical splits, unfinished business, for example) that lead to specific therapeutic tasks (such as two-chair work or empty-chair work, among others; Elliot, Watson, Goldman, & Greenberg, 2004; Greenberg, 2004, 2006; Greenberg, Rice & Elliott, 1993; Greenberg & Watson, 2005).

3.3. Measures

Innovative Moments Coding System (IMCS – Gonçalves, Ribeiro, et al., 2011). This coding system presents 5 mutually exclusive categories of IMs – action, reflection, protest, reconceptualization and performing change – coded from transcripts or videos of therapy sessions. This system uses IMs' *salience* as a measure, that is, the proportion of the session that each IM occupies. Previous studies presented strong inter-judge agreement on the coding of IMs (Hill & Lambert, 2004): Matos et al. (2009) reported 86% agreement on IM' salience and a kappa of .89 between 2 judges in the categorization of IM types; one other study by Gonçalves, Mendes, et al. (2011) reported 86% agreement on IM' salience and a kappa of .97. In another study that used these six EFT cases, Mendes et al. (2010) reported 89% agreement on IM' salience and a kappa of .86 between 2 judges for IM types.

Assimilation of Problematic Experiences Scale* (*APES* – Stiles, 1999*). The APES describes a progression of 8 qualitatively distinct stages in the assimilation of problematic experiences during psychotherapy (Stiles, 1999, 2001). Each stage has specific cognitive and affective features describing how clients relate to problematic experiences. The 8 stages are organized in the following sequence: 0) Warded off/dissociated; 1) Unwanted thoughts/active avoidance; 2) Vague awareness/emergence; 3) Problem statement/clarification; 4) Understanding/insight; 5) Application/working through; 6) Resourcefulness/problem solution; and 7) Integration/mastery. Any shift from lower levels to higher levels of assimilation is considered therapeutic progress (Osatuke et al., 2011; Stiles, 2001).

3.4. Procedures

Overview of the method of task analysis. According to Greenberg (1984, 2007; A. Pascual-Leone, Greenberg & J. Pascual-Leone, 2009), the method of task analysis involves two sequential phases: the discovery-oriented phase and the validation phase (we will elaborate here only the first phase since validation is not the focus of this article). In the first phase (discovery-oriented), researchers need to carry out six analytic steps (Aspland et al., 2008; Greenberg, 2007; A. Pascual-Leone, Greenberg & J. Pascual-Leone, 2009): 1) Define the specific therapeutic task and operationalize its markers (i.e., its beginning and end points); 2) State the researcher's assumptions and expectations involved in ideal resolution; 3) Define task context/environment; 4) Depict a rational model of the task (i.e. *rational analysis*); 5) Contrast the rational model with the analysis of actual performances (i.e. *empirical task analysis*); and 6) Synthesize a rational-empirical model (i.e. refine the model through deletion, alteration and addition of essential steps).

Rational analysis. We departed from the assumption that self-narrative change is a product of co-construction between clients and their interlocutors (e.g. therapists) aiming to characterize in-session client process as well as therapist performance. Therefore, we decided to focus on the client-therapist dyad in the EFT treatment of depression, as the context where this task unfolds.

We assumed that the task begins with the exploration of a problem in the session (beginning point) and ends *successfully* if the client expresses a changed view of the self, organized in a new self-narrative (end point). We used the consolidation of reconceptualization within a same theme (that is, the repetition of reconceptualization IMs or, alternatively, the emergence of performing change IMs after the first reconceptualization IM) to locate the occurrence of the narrative reorganization of the self within a session. Taking into account the findings from previous studies using the IMCS (revised above), the consolidation of reconceptualization signals the client's changed view of the self and self-narrative transformation. Congruently, if the client begins the exploration of a problem and reconceptualization does not emerge within that theme, this was considered *unsuccessful* task resolution. Moreover, the emergence of

reconceptualization IM that is not followed by a new reconceptualization IM or a performing change IM – i.e. non-consolidated reconceptualization – was considered *partial* resolution, but these cases were not sampled for this study.

The first and last authors, drawing upon the findings from previous case studies on narrative change in EFT (e.g. Cunha et al., in press; Gonçalves et al., 2010) and personal training in experiential and narrative therapies, constructed the rational model of narrative reorganization in EFT putting into evidence their expectations towards this process. At this stage, the model was presented and discussed with two research teams (research group headed by the fourth author and research group headed by the sixth author).

Empirical analysis. To conduct the empirical task analysis, the rational model was contrasted with actual successfully resolved tasks derived from the six EFT cases. To allow this, the following steps were taken first: a) Sampling of in-session episodes were the task appeared (complete sessions or session segments); b) Categorization of these episodes according to *successful resolution* criteria to be analyzed subsequently; c) Initial contrast of 3 successfully resolved episodes and 3 unsuccessfully resolved episodes; d) Extend contrast of the rational model with several successfully resolved episodes until reaching saturation (i.e. a new episode does not add further alterations or deletions); and e) Synthesize the new rational-empirical model.

The selection of episodes was conducted by the first author working with another researcher (MA student), following the procedures of consensual qualitative research (Hill, et al., 2005) to arrive at the categorization of problematic themes being talked about in the session and the subsequent excerpting. Then, the following criteria for *successful resolution* were established: i) During the dyadic exploration of a problematic theme, a reconceptualization IM with high levels of assimilation (APES≥6) emerges; ii) Within that same theme, another reconceptualization IM appears or, alternatively, a performing change IM appears (i.e. consolidation of reconceptualization). The APES was used as a global index of resolution of the task, distinguishing the quality of reconceptualization IMs (the validity of the APES as an external indicator of the quality of reconceptualization was presented in a previous study; Cunha, Martins, et al., 2011). All

the reconceptualization IMs in the six cases were coded according to the APES and only the ones with higher levels of assimilation were selected for further analysis (one episode that satisfied these criteria was excluded because the focus was not narrative reorganization but therapy termination). All the episodes that satisfied the resolution criteria came from the 3 good outcome cases. The reconceptualization IMs that reached an APES level equal or higher than 6 accounted for 38.9% (n=42) of the reconceptualization IMs in this EFT sample (see Cunha, Martins, et al., 2011, for details).

From this stage on, the first author worked with another researcher (PhD, third author) to compare 3 non-successfully resolved episodes (i.e. exploration of a problem that does not lead to the emergence of reconceptualization IMs within that theme) with 3 successfully resolved episodes in order to distinguish successful from non-successful resolution, by consensual discussion. Afterwards, the rational model was refined in the contrast with new episodes (through deletion, alteration and addition of essential steps) until saturation (new episodes did not change the model). Model saturation occurred after 9 episodes, although the investigators kept analyzing until the 12th episode. Finally, the rational-empirical model was synthesized into a diagram and subject to an auditing process (by the second author and his research team). At this stage, the rational-empirical model was also presented to the sixth author and discussed with her research team.

4. RESULTS

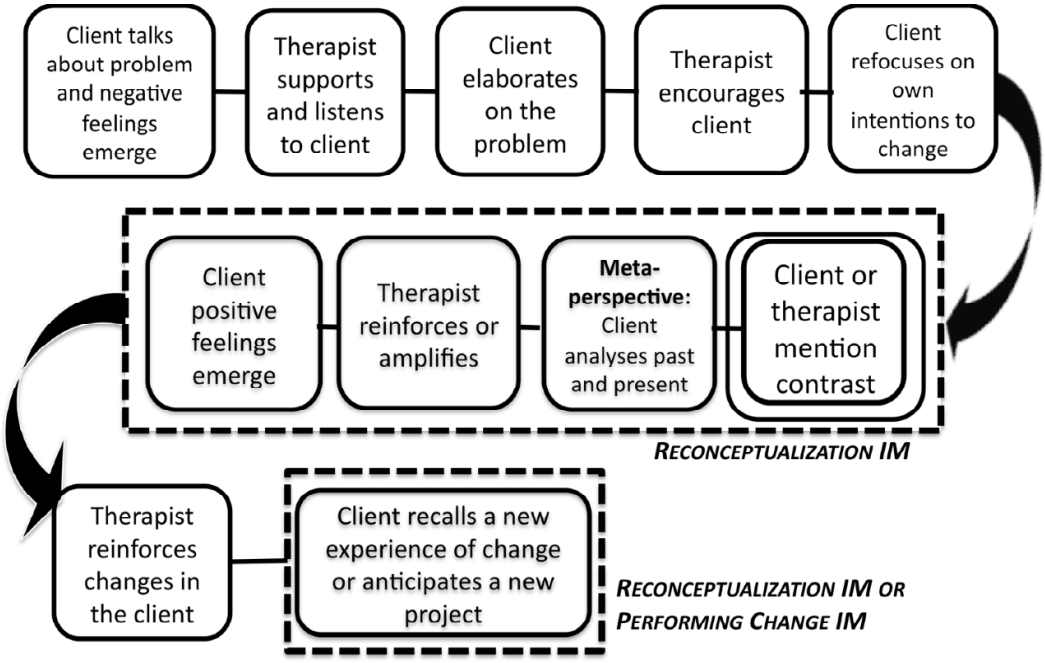
4.1. Rational analysis

The rational model of the task was produced through consensual discussion by the investigators and showed ten steps (figure V.2).

It was proposed that after the identification of the beginning marker – *client talks about the problem* – negative feelings would appear. A successful resolution of the task would start with *therapist support and active listening* (step 1), as the therapist responds by providing space to listen to the client and evidencing support to the experience of the problem and negative feelings that accompany it. This guides the *client to further elaborate on the problem* (step 2) and to *therapist encouragement* (3). This process of problem elaboration and encouragement facilitates a conversational move, as the *client*

refocuses on personal intentions to change (4), leading the way to the emergence of a reconceptualization IM (hereafter RC IM). This type of innovation can either start with *client or therapist mentioning contrast* between the present and the past (5), in terms of client's efforts to produce changes. In turn, the *client further analyzes the past and the present, showing a developed meta-perspective upon the self* (6). This is *reinforced or amplified by the therapist* (7) and then *client positive feelings emerge* (8), ending the RC IM. Subsequently, the *therapist reinforces the changes experienced by the client* (9) and this facilitates the *client's recollection of a new experience of change* that was already practiced in real life, with the re-emergence of a new RC IM that ends the successful resolution of the episode (10 – that is, reconceptualization repeated within the same theme). Alternatively, the last step of the model can appear in the form of a performing change IM (hereby PC IM) instead of a RC IM. In this case, the *client anticipates a new project or experience of change, or expresses new personal resources* that were developed to deal with similar problems in the future.

Figure V. 2: Rational model of narrative reorganization



4.2. Empirical analysis

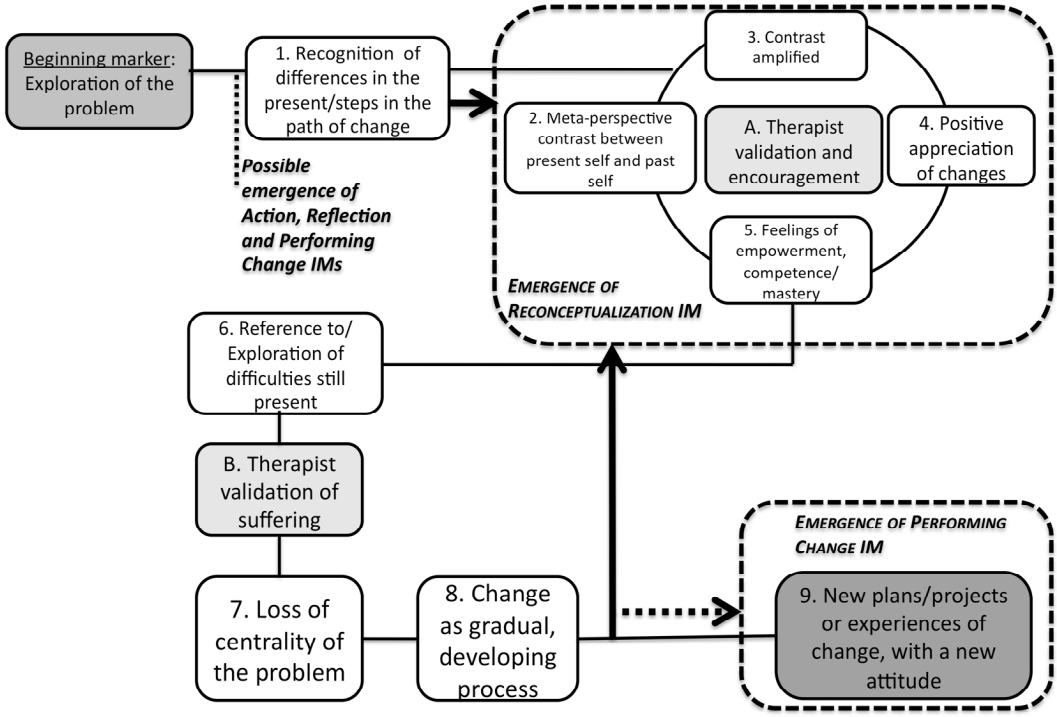
We identified 19 successfully resolved episodes in the three good outcome (GO) cases. These GO cases will be here referred by their fictional names of Lisa, Jan and Sarah (already adopted in previous case studies). Table V.2 shows the distribution of the episodes in the GO cases and the sessions where they were identified. This distribution indicates that successfully resolved episodes were more frequent at a final stage of EFT treatment.

Table V. 2: Distribution of successfully resolved episodes in the good outcome EFT cases and sessions from which they were extracted

Good outcome cases and length of treatment	Number of successfully resolved episodes identified	Sessions and number of episodes selected
Lisa (15 sessions)	4	Session 10 (n=1); 11 (n=1); 15 (n=2)
Jan (16 sessions)	5	Session 14 (n=2); 15 (n=2); 16 (n=1)
Sarah (18 sessions)	10	Session 10 (n=1); 16 (n=3); 17 (n=2); 18 (n=4)

The empirical task analyses led to the synthesis of the rational-empirical model of narrative reorganization in EFT displayed in figure V.3. According to the findings, the successful resolution of the task involved 9 steps, occurring after the identification of the beginning marker. All of these 9 steps were present in every episode; therefore, they were considered necessary for task resolution (there were also some optional features, which will be elaborated below as well.) We will now proceed to a step-by-step elaboration of the model, using illustrative session excerpts (due to space constraints, these were shortened and edited to avoid speech repetition and hesitations).

Figure V. 3: Rational-empirical model of narrative reorganization in emotion-focused therapy for depression



Beginning marker: Exploration of the problem and change. In the confrontation with actual client–therapist performances, we realized that either client or therapist can carry out the exploration of the problem and that this exploration usually occurs with a positive affective tone, already entailing (at least implicit) references to change. These references may take the form of an IM. For example, the client may talk about past attempts to address the problem or a problematic experience that had an unexpected positive ending. Alternatively, the therapist may initiate conversation by exploring where the client is at the present moment (without directing to problem elaboration) and the client responds by elaborating on change, implicitly referencing the problem. Therefore, IMs (usually of reflection type) can follow the beginning marker. An example could be:

Therapist (T): Yeah, that's good. So, how are you?
Client (C): *I'm much, much better. It's getting better all the time*
T: Hmm - that's good to hear

C: I didn't cry once this past week (laughs)

T: That doesn't mean crying is bad

C: No, no, I don't mean it in that way. I meant it that I wasn't losing control, that I was not ah, unhappy or whatever

[Jan, beginning of session 14, transcript page 1 of 31; Reflection IM in italics; References to the problematic self-narrative underlined]

Step 1: Explicit recognition of differences in the present and steps in the path of change. At this stage, all clients explicitly acknowledged differences concerning how they dealt with the problem and that some progress had been achieved in the path to change. Several IMs appeared here, mainly of the reflection type (but also performing change or action IMs). These types of innovation led way to the emergence of RC IMs. Therapists frequently complemented the process of acknowledging differences by underlining the client's agency beneath the changes and using metaphors. An example could be:

C: … *there are all these little certain things happening, I shouldn't belittle it, all these different things happening and I don't know if I have taken away from that like before just by putting up these barriers, probably, but it seems like it's all at the right time, just a really good learning experience.*

T: *Yeah, I guess I don't see it so much as a coincidence, it sounds like you're making some changes. It's like when you throw a pebble in a river and there's one ripple but then there are many more ripples.*

C: *Yeah that's, yeah that's a good way to describe it.*

[Sarah, session 10, page 8 of 19; Reflection IM in italics]

Step 2: Meta-perspective contrast between present self and past self. In this phase, clients adopted a meta-perspective stance upon them and depicted a contrast in the self: the self in the present as distinct from the self in the past. A meta-perspective appears when clients assume an observer position upon themselves; this frequently led

them to recognize something new about the problem or themselves. This meta-perspective usually appeared linked with the recognition of problematic patterns (for example, in interpersonal relationships, in the access to problematic feelings and primary emotions or in the reaction to specific environmental triggers) and was usually expanded by the therapist (through the use of exploratory questions, empathic reflections or restatements). Furthermore, the development of such meta-perspective in the self also allowed the client's disengagement with a former self-narrative. This process was always captured within a RC IM. An illustration is presented below. It depicts the emergence of the meta-perspective (client refers to the process of self-observation and self-reflection), which is then enhanced and facilitated by the therapist (exploring for the results of this self-observation) and leads to the recognition of a relevant interpersonal pattern (contrast in the self: before client hoped she could change the husband; now she realizes his blaming attitude and unwillingness to change):

> C: … *I have been looking at myself and the way I can change but, he* [husband] *doesn't find any fault in himself and that's why it's never going to change unless he really sees what he's doing or hears it maybe from his own child or something like that*
>
> T: *Mmhm, but you don't feel hopeful about him ever changing*
>
> C: *No, I don't, no matter how. If I will say, "you know you're doing this or do you realize you're doing this?" he just ignores it or says it's not him; it's me that has the problem.*
>
> [Lisa, session 15, page 11 of 24; RC IM with APES=6 in italics; Client' new recognition of the problematic pattern underlined]

Step 3: Contrast amplified. The amplification of the contrast was carried out through the elaboration of the differences between the present and the past, for example, in terms of behaviors, interpersonal or emotional reactions, and different client attitudes. It frequently appeared and was expanded through therapist activity (exploratory open-ended questions, restatements or reflections of feelings), capturing the most poignant aspects of client's experience (note the underlined part of the following example):

C: … *I come into therapy and …, I'm trying to keep the family together (T. Mmhm). And those are the changes that I, the way that I approach him is different now*

T: *Mmhm. <u>How is it different</u>?*

C: … *well I don't nag him, I don't put him down and I don't like to criticize him.*

[Lisa, continuation of the same excerpt on session 15, page 11 of 24; RC IM with APES=6 in italics; Therapist activity in the amplification of contrast underlined]

Step 4: Positive appreciation of changes. In this phase of the process, a positive affect tone was present in all the episodes, as clients and therapists valued the changes already achieved and elaborated them in the conversation. Affect was usually optimistic, content and proud. Therapists always responded by validating and encouraging the client's efforts and trajectory towards change, sometimes through the use of metaphor (underlined part in the next excerpt):

C: … *I had to discover who I am first (T: mm-hm) and this has been, you know, an excellent thing for me (T: mm-hm) that has made me realize, you know, um, to explore on my own thinking ... and I really needed it …*

T: *<u>So maybe there is something about now that made you feel ready eh?</u> ... <u>Something brought you to this place now, and I guess something inside you felt ready to deal with things, 'cause, you know, you opened doors that weren't easy to open</u> (C: mm-hm) <u>they were very, very painful</u> (C: mm) <u>and very difficult - but you did and you persevered and you struggled through it</u> … <u>and I think the hard work's paid off.</u>*

[Jan, session 16, page 16 of 31; RC IM with APES=6 in italics; Therapist validation and encouragement underlined]

Step 5: Feelings of empowerment, competence and mastery. The positive affect tone that clients expressed as changes became more concrete and real and the problem more distant led to a renewed feeling of empowerment in the way they dealt with problematic experiences, with higher sense of personal competence and mastery in present life. This appeared explicitly (see the example below) or implicitly in the conversation. Therapists were likely to validate, encourage and reinforce this process through paraphrasing or mirroring the most poignant aspects of client's experience (sometimes through metaphors about change). Reconceptualization IMs usually ended at this stage.

C: … *before I never knew it existed* (laugh) *(T: mmhm) so I'm an individual (T: An individual) Yeah, yeah, I realize I'm an individual and I have the right to vent my feelings and what I think is right or good for me (T: uhhuh) and that's been the improvement of the therapy*

T: *Yeah, really finding your feet*

C: *Mmhm, as an individual yeah, which before I thought I was glued to him* [Lisa's husband]*, I didn't have an existence and now I do and that's a good feeling (T. yeah)*

T: *Yeah and that's pretty important.*

[Lisa, session 15, page 14 of 24; RC IM with APES=7 in italics; Therapist validation and encouragement underlined]

Step 6: Reference to or exploration of difficulties still present. After the positive attitude that marked RC IMs all the clients directed the therapeutic conversation towards the reference or exploration of difficulties still present. All therapists responded to the expression of difficulties by showing several forms of validation of suffering – frequently through empathic affirmation, normalization of the difficulties or portraying change as a work in progress (underlined part in the excerpt below). No IMs were found at this stage.

C: Yeah, I noticed that my husband doesn't feel threatened or like that, but then I guess when I'm talking to him, I also have to do it in a way, ah, that doesn't come across as being threatening

T: Mmhm ... in many ways I think that in the short time you have come to experience yourself differently and others differently and I think that if you can hold onto that and keep struggling with these issues, which will continue to be a struggle (C: yeah) we always struggle with things um, you know, who's to say that things – things can't continue to change and evolve? (C: Mm-hm)

[Jan, session 16, page 25 of 28; Therapist validation of suffering underlined; no IM in this excerpt]

Step 7: Loss of centrality of the problem. Therapist's validation of suffering was followed by a reference to the loss of centrality of the problem in the client's lives. This usually indicated a shift in the expectations regarding change, frequently by portraying a more moderate and realistic perspective or by assigning more importance to other dimensions of life (further away from the problem). This process usually involved IMs (e.g. reflection IMs):

C: … *Yeah, I do have my goals and my ideas and all these things, but nothing is really one hundred percent, I think that's another kind of big thing* (…) *First of all, there is nothing one hundred percent and then also well, it's okay to goof up (T: Mmhm) because you learn from your mistakes, I suppose, and also it doesn't have be perfect as long as I know I did the best I could and I didn't get really like too hyped up about it and too stressed up about it. That kind of helps too.*

[Sarah, session 16, page 12 of 20; Reflection IM in italics]

Step 8. Change as a gradual, developing process. At this stage, all clients explicitly expressed the idea of change as a process still unfolding and happening

gradually over time, instead as a dramatic shift in their lives. There was more serenity accompanying a clearer orientation towards what they needed to do to understand how to deal with remaining obstacles or challenges, no longer feeling overwhelmed by them. Therapists frequently reinforced this process, through expanding metaphors, through restatements and empathic reflections of feelings. Sometimes IMs were present (e.g. reflection IMs).

> C: Yeah, like you said, it's a starting point of planting that seed and then (T: Right) going back to it and just evaluating yourself (T: Mmhm) and asking yourself you know, maybe I should be a little bit more understanding here or
>
> T: Huh uh so somehow it helps you in the world right, I mean you have you can always work from that place (…) and that sometimes life is difficult and sometimes things are sad or lonely and hard and yet you have the ability to go back and feel that
>
> [Lisa, session 15, page 14 of 24; no IM in this excerpt]

Step 9. New plans, projects or experiences of change, with a new attitude. The joint reflection about change within therapeutic conversation always triggered an elaboration upon new experiences of change, new plans and projects that clients were conceiving or already experiencing, with a new attitude to life. This elaboration led more frequently to the emergence of new RC IMs (when clients focused experiences that already happened; bold arrow pointing to the reconceptualization cycle above in figure 3) or, alternatively, performing change IMs (if they focused more on the anticipation of new experiences of change; dotted arrow pointed ahead to performing change). An example of this process follows:

> C: … *I was able to actually bring up the subject and talk to him* [Jan's husband] *about it, as before in the past I'm afraid to say something because he'd take it the wrong way, and he'd take it as though I'm*

sort of attacking him, that he's lazy or not working hard enough or whatever

T: *So you're feeling kind of more freed up, it sounds (C: Yes) Like to be able to bring up things with him (C: Mmhm) and talk about things a lot more, kind of less afraid, it sounds like - less cautious about approaching him*

[Jan, session 14, page 8 of 31; PC IM in italics]

4.3. Central aspects of EFT therapist activity

The role of the therapist was already evidenced in the previous section, during the presentation of the several steps of the rational-empirical model. Yet, in some moments, therapist activity assumed a crucial feature for task unfolding. Given that there were a number of interesting moments where therapists consistently engaged in, we will now proceed to address the central aspects that highlight the productivity of therapist activity at specific junctures.

During the *explicit recognition of differences in the present and steps in the path to change* (step 1 of the model), whenever clients talked about the present changes without explicitly referencing their role in them (e.g. portraying these as somewhat random), therapists always intervened with the aim of stressing client's agency in the process (e.g. "*I don't see it as much as a coincidence, it sounds like you're making some changes.*" – Sarah's therapist, session 10). This facilitated the shift to the emergence of a meta-perspective in clients (step 3 and beginning of RC IMs).

Another productive moment of therapeutic activity relates to *therapist validation and encouragement* (dark grey box A in figure 3) that allowed the progression from steps 2 to 5 of the model. This validation and encouragement while clients were talking about changes in the self and renewed agency seemed central to feed the circular steps within reconceptualization, thus facilitating the identification with a new self-narrative and the consolidation of a narrative reorganization of the self.

Another important process was *therapist validation of suffering* (dark grey box B in figure 3), contingent to client's *reference or exploration of difficulties still present* (step 6 of the model). This process seemed to allow the important shift from problem

elaboration to reflection on change. This particular step from therapists was consistent across the several episodes, even though it could appear in several forms (e.g. empathic affirmation, empathic exploration, or reflection of feelings). A particular alternative that appeared optionally at this stage was *therapist normalization of difficulties*, providing an expert reassurance quality to therapist validation (e. g. "*but you're also aware that, you know, this is sixteen sessions and there are still lots of things in there and there will be setbacks*" – Jan's therapist, session 16; "*suddenly you realize hey, lots of people are struggling with lots of different things*" – Sarah's therapist, session 10).

Even though therapeutic interaction was most frequently characterized by non-directive interventions capturing the core aspects communicated by clients (such as emphatic reflections of feelings and restatements), such interventions frequently facilitated and consolidated the direction towards self-narrative change. Another strategy appeared frequently and consistently across therapists and episodes to achieve this amplification of meaning: metaphor use. Therapists typically presented metaphors as a way to convey rich images and amplify the poignant aspects of the change process (e.g. "*you opened doors that weren't easy to open*" – Jan's therapist referring to the therapeutic process, session 16; "*It's like when you throw a pebble in a river and there's one ripple but then there are many more ripples.*" – Sarah's therapist referring to the ongoing change process, session 10; "*Yeah, really finding your feet.*" – Lisa's therapist referring to her client's new, more grounded attitude in life, session 15).

5. DISCUSSION

In this study, we investigated the process of narrative reorganization of the self that occurs in EFT for depression, through the method of task-analysis (findings of the discovery oriented phase). We focus on the dyad, in order to characterize not only the essential components of client process but also the more productive aspects of therapist activity. Given that the repetition of reconceptualization IMs and the articulation of reconceptualization with performing change IMs were found as markers of good outcome therapy in previous studies (Gonçalves, Mendes, et al., 2011; Matos, Gonçalves, Santos & Martins, 2009; Mendes et al., 2010, 2011), we use these IMs to locate and capture this

fluid process within the EFT sessions. The sampling of successful episodes provided some support to the idea that this task is more typical of a final phase of EFT, occurring after the work on emotion processes has already helped clients experience significant changes (Angus & Greenberg, 2011).

The departing rational model postulated ten steps for the successful completion of the narrative reorganization task. The revision of the rational-empirical analyses arrived at nine essential components. Therefore, after the detection of the beginning marker – exploration of the problem and change – the successful completion of the task involves the explicit recognition of differences in the present and steps in the path of change (step 1); the emergence of a meta-perspective contrast between present self and past self (step 2); the amplification of contrast in the self (step 3); the positive appreciation of changes (step 4); feelings of empowerment, competence and mastery, accompanied by therapist validation (step 5). The task then leads to a reference or exploration of difficulties still present (step 6), which is supported by therapist' validation of suffering, leading to a loss of centrality of the problem (step 7) and portraying change as a gradual, developing process (step 8). The task ends with new plans, projects or experiences of change (step 9) that are reported by the client. Throughout this task, IMs are present at several stages. They can appear during the exploration of the problem and change (beginning marker) and also during the explicit recognition of differences in the present and steps in the path of change, being mainly reflection IMs. Steps 2 (meta-perspective contrast in the self) through 5 (feelings of empowerment, competence and mastery) occur during a reconceptualization IM. Although step 6 never presented IMs, they usually emerge again during step 7 (loss of centrality of the problem), typically in the form of reflection IMs and also during step 9 (new plans, projects or experiences of change, with a new attitude), where they can be either new reconceptualization or performing change IMs.

Regarding the present task of narrative reorganization, we can say that, globally, therapeutic activity appears as a collaborative effort that is constant across the several steps of the model and congruent with the emotion-focused therapeutic stance. However, several instances of dyadic interaction evidence *tangential processes*. These are defined as moments of dyadic activity appearing in the form of *if-then* contingent actions (if the client does X, then the therapist does Y) that become explicit at specific junctures of the

therapeutic conversation (see Bennett, Parry & Ryle, 2006). The first tangential process appears when clients are elaborating the contrast in the self, adopting a meta-perspective, or feeling positive and proud of what they have accomplished so far. This always leads to therapist validation of these changes: that is, therapists not only support clients when they are talking about their new sense of self, but also expand this self-observation standpoint and work through this meta-perspective. This is viewed consensually in the literature as an important process that mediates therapy change, and has been addressed from various angles as the development of meta-cognitive skills (Dimaggio & Semerari, 2004; Salvatore, Dimaggio & Semerari, 2004; Semerari et al., 2007), a new sense of authorship (Angus & McLeod, 2004; Botella, et al., 2004; Gonçalves, Matos & Santos, 2009) or the enhancement of an observer position in the self (Leiman, in press). This general agreement across therapeutic modalities upon the importance of enhancing client self-observation skills in psychotherapy leads Leiman (in press) to propose that this comprises a "fundamental twin process of all psychotherapies" – i.e. a common process across models. However, Leiman (in press) also remarks that this tool of self-observation is only effective when clients can make a productive use of it. Therefore, further attention needs to be paid addressing more systematically how therapists should enhance self-observation within specific dyadic contexts and deal with possible difficulties.

A second tangential process appears when clients are referencing some difficulties still present in the change process or exploring them (step 6), which is always followed by therapist' validation of suffering. The contingency of these processes suggests that therapist's acknowledgement of client's difficulties, consistent with the client centered relationship stance, is still important at an advanced or final phase of therapy in this model and is consistent with a good practice of EFT. Furthermore, this also seems crucial for the adoption of a more realistic view upon the change process and leading the dyad to acknowledge the loss of centrality of the problem (step 7). As the assimilation model (Stiles, 1999, 2001) has highlighted, when higher levels of assimilation are achieved, problems loose their centrality in the lives of clients. This means that the problematic experiences are no longer disturbing clients as they used to or becoming a reason for worry, something that has also been related to successful outcome in some of these same cases of EFT for depression (e.g. Brinegar et al., 2008; Honos-Webb et al., 1999, 2003).

Several steps of this model also involve the activation of specific autobiographical memories in clients combined with positive feelings. This usually happens when clients disclose present difficulties in the change process (step 6) or talk about new experiences of change, articulated as reconceptualization IMs or performing change IMs (step 9) and expressing empowerment, optimism and pride in their accomplishments. This is an important process since, as Boritz, et al. (2008, 2011) have demonstrated previously, good outcome is favored when depressed clients are able to present more specific autobiographical memories in combination with higher levels of positive emotional arousal at therapy termination.

Finally, we notice that the therapeutic strategies are essentially related with a collaborative style from therapists characterized by non-directive, exploratory interventions expected at this phase (Angus & Greenberg, 2011; Greenberg, 1984, 1991; Greenberg, Rice, & Elliott, 1993). Furthermore, exploratory interventions have also been related to reconceptualization and performing change IMs in a previous study with this sample (Cunha, Gonçalves, et al., 2011), evidencing their key role in the productivity of EFT, particularly in the narrative changes achieved in this context. A final note, concerning the use of metaphor by therapists. Metaphor construction, although not an essential component of the task, is also noteworthy across several steps of this process. Previous studies on metaphor use conducted by Angus and colleagues (Angus & Rennie, 1988, 1989; Levitt, Korman, & Angus, 2000) have pointed out that therapist participation in metaphor generation, particularly when adopting a collaborative style (characteristic of EFT), is useful for facilitating the experiential engagement of clients, the description of subjective experiences and the discovery of new forms of self-narrative expression, important for the narrative reorganization of the self.

6. LIMITATIONS AND IMPLICATIONS

The small sample is a major limitation of this study. In addition, the sampling procedure used lead to the selection of episodes from only the three good outcome cases (and respective dyads) that existed in this sample, because none of the episodes from the poor outcome cases met the criteria for successful resolution. This means that our

findings may not generalize to other EFT dyads. Moreover, these findings are limited to depressed clients who are willing to participate in research. In this sense, future studies should be conducted with other dyads to test the generalizability of the preliminary rational-empirical model that was presented here.

Some of these limitations could be overcome in the future by securing a broader sample of EFT client-therapist dyads in the treatment of depression and accomplishing the validation phase of task analysis to establish predictive and external validity of this rational-empirical model in terms of distinguishing good from poor outcome therapy. According to the guidelines of the method (Greenberg, 2007; A. Pascual-Leone, Greenberg & J. Pascual-Leone, 2009), the validation study needs to be conducted with a new sample of cases from which new episodes can be selected and tested through independent assessment carried out by several judges.

Another important limitation was the fact that we only had access to transcripts for this study, which means that our present findings might have been impoverished due to limited access to fundamental non-verbal components of client-therapist interaction. Hence, future studies should expand this preliminary task-analytic model with analysis done with audio and video recording of real performances to see if further refinement needs to be carried out before pursuing other empirical goals.

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CONCLUSION

CONCLUSION

The good life is a process, not a state of being.
It is a direction not a destination.
(Carl Rogers, 1961, p.186)

The final section of this dissertation aims to reflect on the contributions offered by each of the previous chapters. We selected different *foci* of therapy process (according to Elliott, 1991) to organize our present discussion upon the overall contributions brought by this collection of research studies: (1) the diversity of reconceptualization innovative moments (IMs – client focus), (2) the therapist contributions to the promotion of narrative change (therapist focus), and (3) the process that unfolds from reconceptualization to the narrative reorganization of the self in EFT (dyadic focus). Finally, we will conclude with a look ahead elaborating future research developments.

ADDRESSING THE DIVERSITY OF RECONCEPTUALIZATION INNOVATIVE MOMENTS

Taking into account the intensive analysis of reconceptualization IMs, carried out by several studies in this dissertation (chapter II, III and IV), one of the first aspects that we must acknowledge is the diversity of client reconceptualization IMs. This refers to the qualitative aspect of these narratives: even though all of these IMs may share the two distinctive features of (i) *recognition of a contrast in the self* and (ii) *description of its transformation process from then (self in the past) to now (self in the present)*, the qualitative differentiation is notorious throughout emotion-focused therapy (EFT). We will discuss here three aspects that trigger this diversity and differentiation: (1) the non-linearity of narrative change, even after the emergence of reconceptualization; (2) the

emergence of ambivalence in the transition to reconceptualization; and (3) the diversity of assimilation processes in reconceptualization IMs.

Our initial confrontation with this diversity came from the case study of Sarah (chapter II). This study represents a theory-building case study (Stiles, 2007) on the narrative transformation of the self through the lens of IMs. Congruently with this research approach, the general aim was to look at the particular features of this case in terms of IMs' evolution and see where they could enrich, complement or challenge the current state of knowledge within the IMs' perspective (Elliott, 2010; Stiles, 2007). One of the goals guiding this in-depth, highly contextual analysis was to understand how reconceptualization IMs in the case of Sarah reflected the developing process of self-narratives during therapy evolution. Thus, we wanted to understand the process of development and function of reconceptualization IMs in the narrative transformation of this client's identity.

This study appears as an enriching step in this dissertation, since several ideas were extracted from it, leading us to subsequent research developments. First of all, the idea that reconceptualization IMs involve the acknowledgment of a rupture or a discontinuity of the self (Zittoun, 2007) guided us to look at reconceptualization as a transition process that clients go through in therapy. In Sarah's case, it was noticeable how this client was trying to make sense of the (behavioural and attitudinal) changes she had achieved during the therapeutic process and what were their implications towards the way she viewed and talked about herself.

The non-linearity of narrative change

One of the contributions from this intensive analysis of the emergence and development of reconceptualization IMs, was the understanding that narrative change can appear as a non-linear process, even in a *post-reconceptualization* phase. That is, in the case of Sarah, narrative change was accomplished in the midst of several progressive and regressive lines in the development of IMs. This means that the salience and diversity of IMs can go back and forth within a case even after the emergence of reconceptualization. This contrasts with the early suggestions made by several authors in this field, who had initially proposed that reconceptualization – due to its capacity for narrative integration –

would initiate a strong directionality in meaning making opposing the former problematic narrative and somehow adding narrative stability and expansion to the previous forms narrative innovation (i.e. action, reflection and protest IMs). For example, Gonçalves, Matos and Santos (2009), when characterizing the role of reconceptualization IMs, emphasized that:

> In the construction of a new narrative it *[i.e. reconceptualization]* acts like a gravitational field that attracts and gives meaning to action, reflection, and protest IMs. These reconceptualization IMs expand further through the elaboration of other IMs, which act as internal validations that change is taking place. (p. 13, emphasis added)

This strong directionality in meaning making is explained, for example, by a dialectical takeover process (see Santos & Gonçalves, 2009) in which a new, emergent voice becomes more dominant than the former, problematic voice. However, the observations in Sarah's case evidence that the transition from a former self-version to a new self-version may not happen so smoothly. This finding, despite not inconsistent with the former proposals leads to their refinement (in another case-study, Ribeiro & Gonçalves, 2010, show another type of fluctuation in the IMs' evolution, this time in terms of content).

This type of fluctuations within a case is in line with the remarks made by Brinegar et al. (2006) on the assimilation of problematic experiences in therapy. These authors noticed that some clients might exhibit an irregular change pattern due to the need of *recycling* previous stages of development before being able to reach a new stable pattern:

> Clients may need to recycle through adjacent substages to deal with closely related threads of a problem. Alternatively, life events may produce setbacks that must be overcome by rehearsing some therapeutic work. Thus, clients' progression may not be strictly linear, as general

> advancement is accompanied by local recycling. (Brinegar et al., 2006, p. 177)

Therefore, recursivity of reconceptualization IMs along the therapeutic process allows the recycling of past functioning through its repeated revisiting which, in turn, permits to deal with ambivalence and uncertainty. Additionally, this recycling process changes the quality of the change process being dealt with. In this case, the recapitulation of the past that is systematically shown along the several reconceptualization IMs fosters the narrative reorganization of the self through the construction and identification with a new self-narrative. The rehearsal of a new stage of development (i.e. of self-narrative development in this case) can sometimes appear in an irregular, *sawtoothed pattern* (Stiles, Osatuke, Glick, & Mackay, 2004; this pattern is illustrated in figures II.2 and II.3 in chapter II). This irregular pattern, resulting from the progression and regression of IMs throughout the therapy sessions of Sarah, can be metaphorically characterized with the expression "two steps forward, one step back" (A. Pascual-Leone, 2009). This means that each time Sarah falls back into a more familiar sense of self (former problematic self-narrative: e.g. passive towards others), the shift towards the identification with a new version of herself (e.g. assertive) gets easier and in the end becomes stabilized. This irregular pattern discovered in the renewal of self-narratives has also been identified and related with other significant change processes in EFT, such as the assimilation of problematic experiences (Brinegar et al., 2006) and emotional processing (A. Pascual-Leone, 2009; A. Pascual-Leone & Greenberg, 2007a).

Emergence of ambivalence in the transition to reconceptualization

Another aspect that we consider relevant is emergence of the ambivalence in the transition to reconceptualization. That is, as clients start recognizing themselves as different than they were in the past (i.e. after the acknowledgement of a rupture or discontinuity in the self) they begin struggling to find a new identity and this transition can be lived with ambivalence and uncertainty.

Previous studies within the IMCS had already addressed the idea of ambivalence in the change process through the concept of mutual in-feeding between problematic and

innovative voice (Gonçalves, Ribeiro et al., 2011; Santos, Gonçalves & Matos, 2010). However, the first reconceptualization IM of Sarah, allowed illustrating a specific form of ambivalence that goes beyond what we had encountered before under the scope of mutual in-feeding. More specifically, this ambivalence or uncertainty is not between the problematic voice and the innovative voice, but was fed between the innovative voice (the self as a new actor) and a meta-perspective commenting on the change process (i.e. an observer position in the self – Leiman, in press; or metaposition – Hermans & Kempen, 1993). This process can be exemplified through Sarah's own words: "*I have to do or say something… I get kind of tense but then I say or do whatever*" (new version of the self: acting assertive) and *"I can't believe how difficult it is… I kind of feel guilty"* (ambivalence expressed at the level of a metaposition – i.e. an inter-level ambivalence, see chapter II).

From these observations made in Sarah's case, we raised the hypothesis that ambivalence would appear also in the initial moments of transition to reconceptualization in other cases. This was elaborated in the study presented in chapter III. Thus, this third study looked deeper into the notion of ambivalence in the change process by analysing the first reconceptualization IMs of three successful EFT cases: the cases of Sarah, Jan, and Lisa. Following the idea that reconceptualization IMs can entail specific forms of ambivalence that go beyond the usual scope of mutual in-feeding between problematic and innovative voice, the goal here was to clarify if other good outcome cases confirmed this statement.

We must recognize at this point that this third study (chapter III) was not as much guided to theory-building purposes like the previous one (chapter II). Instead, it fits more congruently with a clinical case approach or a "qualitative" case study, according to Iwakabe and Gazzola (2009). This design highlights the clinical observations of a case or of significant clinical events (presented in the three vignettes from the cases), in order to demonstrate relevant aspects of theory (Iwakabe & Gazzola, 2009). So, the purpose was demonstration, not theory-building. Nevertheless, in the overall framework, we assume that it provided us increasing theoretical refinements regarding mutual in-feeding and the ambivalent processes probably associated to reconceptualization IMs (due to increasing confidence in some of the hypothesis raised previously in Sarah's case – Stiles, 2007).

In particular, the three vignettes selected from the cases of Sarah, Jan and Lisa (chapter III) showed that ambivalent processes can appear in reconceptualization IMs mainly according to three different forms: 1) mutual in-feeding between problematic narrative and innovative moments (or between problematic and innovative voice, in more dialogical terms), which appeared in the cases of Sarah and Lisa; 2) related to the fear of failure in the path to change, regardless of personal efforts being made and the help of the therapist, which appeared in the case of Jan; and 3) expressed by the metaposition, as in the case of Sarah (as an inter-level ambivalence, expressed by the self as an actor of changes and an observer position, commenting on the changes). Future studies need to be carried out in order to provide validity for this theoretical differentiation and further empirical support on this issue. According to what was observed in these cases, we speculate that the resolution of these types of ambivalent and mutual in-feeding processes in psychotherapy requires a working-through in a meta-perspective or metaposition of the self that can be enhanced by specific therapeutic strategies (more of this below).

Due to the small sample (of clients and excerpts) of these studies and being aware of the criticisms directed to case studies in general (namely, the possibility of logical errors or biases in interpretations – Iwakabe & Gazzola, 2009), it was important for us to pursue further systematic analysis of reconceptualization IMs, with more reliable methods and to carry out the systematic comparison of significant in-session episodes related to reconceptualization. Hence, another research development in this line was presented in chapter IV, using the assimilation model as a lens to grasp and describe the diversity of reconceptualization.

The diversity of reconceptualization IMs in terms of assimilation

The fourth study (chapter IV) followed a process-outcome design (Elliott, 2010) in order to provide one step further in the clarification of the theoretical statements raised by the previous studies. Therefore, this study aimed to analyse the heterogeneity of reconceptualization IMs and illustrate their qualitative differentiation of reconceptualization during the evolution of EFT. We also wanted to understand if the repetition of these IMs during therapy leads to an improvement of their clinical

productivity. At last, we were interested in analysing these goals in the contrast between outcome groups and therapy phases (initial, middle and final).

We used the assimilation model – a model that has provided ample proof regarding its research applicability and clinical usefulness – as a tool to systematically analyse reconceptualization IMs. Since the assimilation model of Stiles (1999, 2001; Stiles et al., 1990) depicts psychotherapeutic change as a developmental continuum of the assimilation of problematic experiences (summarized in the APES), we assumed that it would be a useful analytic tool to describe the development of reconceptualization. Furthermore, as this model has been successfully applied to EFT for depression on several other occasions (with consistent results both for EFT and for assimilation theory – e.g. Brinegar et al., 2006; Honos-Webb et al., 1998, 2003), it was also considered useful for the analysis of reconceptualization IMs emerging in this sample.

To recapitulate briefly, the findings from this study show that the 108 reconceptualization IMs appearing in the six EFT cases were coded with very different APES levels (ranging from 1 to 7), although the large majority fell in the 4 to 6 assimilation stages. This means that most reconceptualization IMs exhibit processes related with higher assimilation stages, such as: a progress in understanding and insight (APES level 4), attempts to work-through and address the problem on a daily basis (APES level 5) or using the problematic experience as a resource when facing similar challenges in daily life (APES level 6). The contrast between the two outcome groups confirmed our initial hypothesis, consistent with the assimilation literature (e.g. Detert, et al., 2006), that the median APES levels of reconceptualization IMs is higher in GO than in PO cases. Moreover, the analysis of differences between therapy phases (initial, middle and final) reveals that reconceptualization IMs show improvements in the assimilation of problematic experiences during therapy.

These findings are consistent with the initial hypothesis that reconceptualization IMs become more differentiated and clinically productive (in terms of assimilation of problems) throughout its repetition during EFT. This is particularly true for the middle and final phases of GO EFT (in contrast with the PO group in the sample studied), where reconceptualization IMs reached higher stages of the APES (a median of 5 in the middle phase and a median of 6 in the final phase).

This study allowed extracting two important implications regarding this EFT sample. The first implication is that these findings support previous theoretical arguments that have been suggesting convergences between the notion of reconceptualization and the higher, more complex stages of the assimilation model. Four of these arguments are:

1) Narratives play a different function along the assimilation continuum: specifically in the later stages of the APES levels, narratives – as reconceptualization IMs – serve to emphasize the therapeutic gains and to review efforts related to their application to the daily life of clients (Stiles, Honos-Webb & Lani, 1999). That is, "By telling stories of application, clients may gain ideas to apply insights more successfully or they may gain self esteem as they review changes they have effected in their lives" (p. 1223);

2) The integration of problematic experiences in the self, providing a sense of personal coherence and organization that was failing before, is an important process both in the APES and in reconceptualization, as Gonçalves, Matos and Santos (2009) and also Pinheiro, Gonçalves and Caro-Gabalda (2009) highlight;

3) The developmental function of reconceptualization stressed by Gonçalves and Ribeiro (in press), facilitating the connection between well-developed positions in the self (related to the problematic narrative) and emergent ones (related to the new self-narrative), is an aspect shared with the assimilation model;

4) The creation of connective links between present and past – a crucial feature of reconceptualization IMs – is an important process both to the assimilation of problematic experiences and to EFT (Honos-Webb, Stiles & Greenberg, 2003):

> One consistent finding across the successful cases was that clients spontaneously connected their present behavior to past experiences in their developmental history. (…) This finding highlights the surprising nature of the "discovery" of connection to historical roots in an experiential treatment (…) One explanation for this phenomenon is that the connection to historical roots is not necessarily a cognitive interpretation but an essential aspect of the present experience. The

> connective links are the unpacking of a new voice being assimilated into the dominant community of voices. (p. 196-197)

The second implication regarding the consistency between our findings and the previous literature on assimilation and innovative moments in EFT concerns an interesting possibility: the combination of both models in order to produce a better prediction of good outcome therapy or, at least, a better prediction of the productivity of reconceptualization IMs. For this reason, the assimilation model can act as a measure of external validity of reconceptualization IMs, which is an important requisite (according to Greenberg, 2007) for the method used in a subsequent study: the task-analysis of the narrative reorganization of the self (chapter V).

THERAPIST CONTRIBUTIONS TO THE PROMOTION OF NARRATIVE CHANGE

According to Elliott (1991), the study of the therapeutic process tends to select one of three *foci* in relation to the elements of the therapeutic system: client, therapist or dyad. Up until now, the focus under the Innovative Moments research group has been on the client, through an understanding of client process in several therapeutic modalities (Alves et al., 2011; Matos, 2006; Mendes, 2010; Santos, 2008;). The previous section of this conclusion is one example of such focus. Despite the importance of the client for understanding narrative change in psychotherapy, there was the need to expand the research focus, in our view, to the analysis of the therapist. Therefore, we consider that one of the most important contributions of this dissertation is precisely to be the first systematic effort to explore the therapist role in the promotion of narrative change – seen through the lens of IMs – in EFT. Furthermore, paying attention to the therapists' contributions is an important step for fulfilling the promise of clinical applications deriving from the IMs' perspective.

Therapist skills related to IMs

We began combining the focus on client process with the therapist behaviour (the dyadic focus will be discussed later), in a first effort to understand how therapists could contribute to the emergence of IMs (chapter I). This first study followed a microanalytic sequential process design, by analysing basic therapist interventions related to the occurrence of IMs and focusing on a comparison between outcome groups: poor-outcome (PO) and good-outcome (GO). As characteristic of this type of studies (Elliott, 2010), the scope is focused and limited to one aspect of therapeutic activity (i.e. helping skills) in the attempt to relate it with a specific immediate outcome (IMs' occurrence at the level of lag 0 – i.e. at the next client turn).

In a brief overview of the main contributions of this study, the following aspects are worth noting: first, the vast majority of skills used by therapists across all therapy phases falls under the category of exploration skills and these skills are used more often across all therapy phases of GO when compared to PO cases (approximately 70 to 80% of the skills used by therapists). This is congruent with a good practice of EFT and particularly with the humanistic stance that inspires the EFT therapeutic relationship (Elliott et al., 2004).

Second, the use of insight skills appears higher than we expected in EFT, an experiential modality that globally discards the use of these skills for attaining the desired therapeutic goals. Moreover, insight skills were more frequently used across all phases of PO (approximately the double) when compared with GO cases. Since these results on insight skills are rather controversial from an EFT perspective, we will discuss them further ahead.

Third, action skills appear much less (approximately 10% of the skills) in the initial, middle and final phases of GO cases (decreasing slightly in the final phase), while in PO cases, action skills keep increasing across therapy phases. Therefore, action skills are more often used in the initial phase of GO when compared with the same phase of PO, but this shifts during the final phase of therapy (since in this phase action skills are used more frequently in PO than in GO cases). We speculate that in GO cases therapists and clients are more frequently engaged in the active tasks (requiring more process directives) already from the beginning of therapy but this does not happen as early in PO.

Instead, in PO cases this engagement in active tasks happens during the middle of treatment and keeps increasing specially in the end (unlike what happens in GO dyads), almost as if clients and therapists were still trying to actively work through some issues in the last sessions of therapy.

Regarding the association of skills with IMs, we choose to highlight here the following two main aspects:

(1) In GO cases, the association of skills with overall IMs is higher in the middle and final phases of therapy (when compared to the initial phase). In contrast, in PO cases, that association is higher in the middle phase of therapy (when compared to the other therapy phases), suggesting a more active participation of interlocutors during this phase of treatment (which is not followed through in the final phase).

(2) In the GO group, exploration skills and insight skills (with no differences between these) precede more often action, reflection and protest IMs in the initial and middle phases of therapy and then precede more often reconceptualization and performing change IMs in the final phase. Action skills appear related to action, reflection and protest IMs across all therapy phases of GO cases and this association is more evident in the final phase of EFT.

Overall, we consider that these results support the model of narrative change proposed by Gonçalves et al. (2009) by highlighting how exploration and insight skills are related to more elementary IMs (action, reflection and protest) during initial and middle phases of therapy. These skills help to set the foundations of narrative change (through the association with action, reflection and protest IMs in initial and middle phases of EFT), and then become related to more complex IMs (reconceptualization and performing change) later in therapy as the client is becoming more engaged with a new self-narrative. In contrast, action skills remain always related to action, reflection and protest IMs across all therapy phases. This makes sense given the especial role that process guidance during EFT chair-work may play in the emergence of more elementary forms of innovation (e.g. protest or reflection IMs) from the beginning until the end of therapy (see Gonçalves, et al., 2010). Furthermore, taking into account the narrative change model, the production of more elementary IMs (action, reflection and protest) is

still relevant for narrative change at later stages of therapy since, as clients become more familiarized with a new self-narrative, it integrates new action, reflection and protest IMs.

A place for insight in EFT? The association between insight skills and IMs raises several issues about their unexpected presence and potential usefulness of these skills in the promotion of client change. Overall, the results on insight skills suggest that the promotion of insight in EFT may be useful for the facilitation of narrative change. In parallel, a previous study by Gazzola and Stalikas (1997) found that most of the interpretations employed in the analysis of six single-sessions of Rogers were related to "good moments in therapy" in terms of client experiencing (three quarters of all interpretations were followed by an higher level of client experiencing, which can be seen as productive moments in EFT).

Yet, assuming that the use of insight skills in EFT may be productive is not a simple statement. Three main reasons justify this claim: first, the use of insight skills by EFT therapists is unexpected according to this model. However, this study is not alone in this finding (e.g. Gazzola & Stalikas, 1997). For example, a previous study by Gazzola and Stalikas (2004) focused one of the insight skills – therapist interpretation – appearing in sessions of client-centered, gestalt/existential and rational-emotive therapies. These authors found that not only were interpretations present in all these therapies (even though these would be discarded in client-centered and gestalt/existential approaches), but also noted that they were exhibited in specific patterns adjusted to the theory underlying each therapy (i.e. the interpretation content and style of delivery).

Second, although insight skills were more frequent in PO cases, they were not as useful as in GO cases (that is, they were less related to IMs' occurrence). We speculate that this happens because therapists are trying to find some way to promote further changes in the clients since the usual exploration skills are not providing the expected results and may more often go beyond where clients are, scaffolding for client changes and development (through insight skills). However, these PO clients do not match this movement producing IMs (unlike GO clients). As Bohart (2000) argues, the effect of therapist activity is more dependent on clients than on what therapists do; thus, if clients

have self-healing capacities (such as we suppose these GO clients do), they can accomplish more with what therapy and therapists provide.

Third, not all kinds of insight are valuable according to EFT. Only experiential insight (A. Pascual-Leone & Greenberg, 2007b), which involves increased awareness, owning and meta-awareness of emotional experience, would be the most productive kind from an EFT perspective.

Therefore, it is clear to us that future studies should be developed on this matter. We emphasize the need to explore the compatibility between the experiential response modes (e.g. Elliott et al., 2004) and the helping skills system used by Hill (2009). For this it would be important to focus on the content and style of each one of the insight skills in order to elucidate some of the issues raised before (an example could be the potential convergences between experiential *empathic conjectures* and therapist interpretation in EFT).

Therapist strategies for dealing with ambivalence

We would like now to move our discussion on therapists' contributions to the studies presented in chapter II and III, which consider psychotherapy and the concrete therapeutic strategies (e.g. techniques, interventions) as ways of promoting client development (Leiman, in press; Leiman & Stiles, 2001; Ribeiro, 2009). The dimension of development focused upon in these two studies was how therapists helped clients to elaborate meaning making and narrative change through the expansion of IMs, and how they helped clients deal with ambivalence in the transition to reconceptualization.

According to this, the intensive analysis of these therapy excerpts allowed to observe several instances when the therapist moved within a familiar zone of problem exploration, while at other moments moved to a more challenging zone by fostering for further differentiation around novelties, signalled by the emergence of IMs (see Ribeiro, et al., 2011, on this issue), after the detection of client ambivalence in the transition to reconceptualization. More specifically, we can depict the following therapeutic strategies used by the three EFT therapists (focused on chapters II and III):

1. Exploring or conjecturing about the client's experience in the attempt to promote further awareness, using first person pronouns (T: *You see, I think there's part of*

you that gets furious and says that's not true and I'm not like that, and there's another part that sort of buys the party line.);

2. Acknowledging current difficulties (focusing on the problematic voice) but also highlighting what is different now (shifting from problematic to innovative voice), sometimes across several turns of therapist talk);

3. Expanding and modelling the integration of past and present (e.g. T: …*you're saying that before the risk that someone might not respond to you used to stop you from trying… and somehow now you say: Okay, maybe they won't respond but some will, and go with the positive* – here we see processes (2) and (3) illustrated);

4. Responding to client difficulties, ambivalence or demoralizing stance through therapist validation and the adoption of the client's voice (e.g. T: *it feels it shouldn't be so difficult*; T: *It sounds like you've been told from very young what you limits are and what they should be and it's hard to believe that you could – as a little child – say: "I won't let it sink in"*) or recapitulating prior, successful efforts (T: *at times you feel the energy and to hell with them, you're up and doing stuff. Then at other times, it's like maybe they're right*)

5. Introducing higher order values or goals associated to change and pushing for further awareness (T: *So you tell yourself what… Keep persisting or just don't give up hope?*)

6. Using metaphors concerning the change process (T: *there's sort of a new stage*…).

We believe that these strategies conveyed the following therapist intentions:

(a) The establishment of a favourable working distance from emotional experience and for building upon client self-observation skills (Leiman, in press);

(b) The validation of client difficulties, providing security and acceptance in particular moments of the therapeutic process (Ribeiro, 2009; Ribeiro, et al., 2011);

(c) The consolidation and amplification of meaning making around what was new and novel, frequently expanding or triggering IMs (Ribeiro, et al., 2011); and

(d) Allowing a working-through of client's metaposition (e.g. Leiman, in press).

This interpretation is congruent with the reviewed literature stressing the importance of developing a meta-perspective, a metaposition or a self-observing stance

(e.g. Castonguay & Hill, 2007; Dimaggio, 2006; Dimaggio, et al., 2007; Engle & Arkowitz, 2006; Gonçalves et al., 2009; Hermans, 2001; Leiman, in press; Leiman & Stiles, 2001; Semerari, et al., 2003). Despite the differences in terminology, all of these authors emphasize the importance of enhancing a self-reflective stance from which clients gain insight and further understanding of their problems and solutions. For example, Leiman (in press), referring to this process of self-observation as a therapeutic tool, states that: "The jointly created reformulation by client and therapist concerning the client's problematic patterns of action and experience underlying the presenting problems will be an effective tool only, when clients can make use of it." (p. 4). We claim along with these authors that it is this meta-level, insightful, self-observing stance that clients adopt upon their own experience and exhibited in reconceptualization IMs, that is helpful and potentially creative in psychotherapy.

These ideas that emerged from these two case studies (chapter II and III) are still very tentative and in need for further clarification. Therefore, new studies need to be carried out to support these strategies or enrich these observations (Stiles, 2007). For example, the application of the *Therapeutic Collaboration Coding System* recently developed by Ribeiro and collaborators (2011) or the use of *Dialogical Sequence Analysis* (Leiman, 2004, in press), which are methods to study the therapy process according to this developmental framework, can be useful for the pursue of more systematic studies in the future.

In the development of this dissertation, we considered that initiating a task-analytic research programme – focused not on client or therapist, but on dyadic process – would be able to discover important aspects to contribute to the understanding of the emergence and consolidation of reconceptualization in EFT.

FROM RECONCEPTUALIZATION TO THE NARRATIVE REORGANIZATION OF THE SELF IN EFT

We decided to discuss the expansion of reconceptualization to a narrative reorganization of the self as a separate section from the previous sections of this

conclusion since we approached this dimension of the therapy process in EFT from a dyadic perspective (Elliott, 1991). The previous studies lead us to conceive narrative change as a product of co-construction between client and therapist – each one with particular contributions – conducting us to the last study of this dissertation (chapter V), which reports the preliminary findings of a task-analysis. According to Elliott (2010), this type of studies falls under a research approach that focuses on the intensive, theory-building analysis of significant change events and, as Greenberg (1984, 1991, 2007) adds, it is oriented to the discovery and validation of processes implied in the resolution of relevant therapeutic tasks.

Therefore, in the last study of this dissertation, the therapeutic task in focus was the narrative reorganization of the client' self in EFT. We assumed that this task begins with the exploration of a problem in a session and ends successfully if the client expresses a changed view of oneself, organized in a new self-narrative. Additionally, and according to the findings from previous studies within the IMs' perspective, we used the emergence and consolidation of reconceptualization IMs within a same conversational theme (i.e. the repetition of at least two reconceptualization IMs in a same theme or, alternatively, the emergence of reconceptualization and its articulation with performing change IMs) as a way to operationalize and locate the process of narrative reorganization within the therapeutic sessions. This follows our previous analysis regarding the emergence of reconceptualization IMs (discussed before), building on Mendes and colleagues' (2010) previous arguments:

> It seems that reconceptualization and performing change IMs play a role in successful emotion-focused therapy for depression. We speculate that with the emergence of reconceptualization the client is engaged in a self-empowered position that provides the scaffolding of the client's authoring of his or her new self-narrative. The emergence of reconceptualization IMs unfolds the client sense of authorship, emphasizing that a new narrative of the self is developing. (p. 699)

The rational-empirical model discovered in this sample of recovered EFT clients establishes that, in this sample, after the beginning marker – exploration of the problem and change – a successful progression of the task evolves through the following nine steps: (1) the explicit recognition of differences in the present and steps in the path to change; (2) the emergence of a meta-perspective contrast between present self and past self; (3) amplification of contrast in the self; (4) positive appreciation of changes; (5) feelings of empowerment, competence and mastery, accompanied by therapist validation; (6) reference or exploration of difficulties still present and therapist validation of client suffering; (7) loss of centrality of the problem; (8) change as a gradual, developing process; and (9) new plans, projects or experiences of change.

The analysis of the twelve different in-session performance episodes in this sample of recovered clients allowed understanding that IMs are present at several stages of task resolution. First, IMs can appear during the beginning marker and also during the explicit recognition of differences in the present and steps in the path to change (step 1), usually in the form of reflection IMs, when clients and therapists talk about remaining problems or changes achieved. Second, reconceptualization IMs involve the emergence of a meta-perspective contrast between present self and past self (step 2), followed by an amplification of contrast in the self (carried out by clients or therapists – step 3), with a positive appreciation of changes from the client (step 4), and increased feelings of empowerment, competence and mastery (step 5). The cycle between these steps is fed by therapist validation and encouragement. Third, the loss of centrality of problems (step 7) is usually marked by IMs, typically assuming the form of reflection. Finally, the last step of the model (step 9), which encompasses new plans, projects or experiences of change is signalled by new reconceptualization or performing change IMs.

The (almost complete) absence of protest IMs across the several steps of this model suggests that this type of IMs do not play an important role at this phase of EFT. As Gonçalves and colleagues (2010) argued, protest IMs in EFT mainly appear in the context of chair-work or as a consequence of these enactments. Moreover, when these authors went to investigate more intensively the evolution of protest IMs according to two contrasting subtypes (subtype I, focused on problem-oriented positions vs. subtype II, focused on creating distance from the problem), they realised that both protest IMs'

subtypes decreased after the middle phase of therapy (see Mendes et al., 2011). Therefore, they hypothesized that:

> the clients' elaboration of positions of empowerment, which are embedded in subtype II of protest IMs, may after the midpoint of treatment be involved in the elaboration of reconceptualization. The new self-positions which emerge in the form of protest IM subtype II may serve as scaffolding for the development of new views of self needed for reconceptualization IMs to emerge. (Mendes et al., 2011, pp. 311-312)

The idea advanced by these authors that protest IMs – so important in a working-through phase of EFT – are substituted by reconceptualization IMs in the final phases of EFT is supported by the previous findings within the IMs' perspective (Alves et al., 2011; Gonçalves et al., 2010; Gonçalves, Mendes, et al., 2011; Matos et al., 2009; Mendes et al., 2010, 2011). Despite this recognition, this study represents, in our view, a step further in the understanding of reconceptualization as a process in itself, which becomes consolidated in therapy. Thus, looking at reconceptualization as a dynamic phenomenon, unfolding in time (Valsiner, 2006) and throughout the therapeutic conversation, allowed to depict the several steps that need to be accomplished so that reconceptualization IMs originate a new full self-narrative.

Implications for the study of therapists' contributions to narrative change

The last study also allowed understanding that EFT therapists consistently engage in and actively participate at specific junctures of the therapeutic conversation during the development of this task. These indicate particular moments of therapist responsiveness (Stiles, Honos-Webb & Surko, 1998). That is, after the detection of specific client processes, therapists tended to exhibit a characteristic set of responses, referred as tangential steps, in the terminology of Bennett, Parry and Ryle (2006). Thus, the tangential steps noted in these GO EFT dyads are the following:

A. When clients explicitly recognize differences in the present and steps in the path to change (step 1), therapists respond in a way that reinforces their clients' sense of agency;

B. When clients go through the steps that constitute reconceptualization (steps 2 to 5), particularly after the clients' expression of an increased empowerment, competence and mastery, therapists convey client validation and encouragement;

C. When clients reference difficulties still occurring in the change process (step 6), therapists respond with validation of client suffering.

The communication of empathic attunement, positive regard and prizing of the client, are particularly visible here. Thus, these therapeutic strategies, taken as a whole, are congruent with the EFT relational stance proposed by experiential authors (Elliott, et al., 2004; Greenberg, 2002, 2006; Greenberg, Rice & Elliott, 1993; Watson & Greenberg, 1998). Moreover, we believe this study contributes to the more detailed understanding of the final phase of the EFT treatment, originally understood within a global context of EFT termination (Greenberg, 2002) but more recently framed within a last phase of consolidation and narrative reconstruction in EFT (Angus & Greenberg, 2011).

In particular, we highlight the following principles by Greenberg (2002), which were made visible through the present task-analytic model:

1) Viewing the client as an agent. This means that EFT therapists reinforce the client's renewed sense of authorship and autonomous agency (visible in steps 2 to 5 of the model);

2) Viewing change as a process. EFT therapists convey that change is not confined within the space and temporal limits of therapy; instead it is a gradual process, which will continue after therapy termination (step 8);

3) Empowering the client. This means equalizing the relationship through assigning to the client the responsibility for the changes although EFT therapists may also acknowledge their part in it. This can involve, for example, an expression of the therapists' own appreciation of the changes clients achieved, as a particular way to convey therapists validation and encouragement (steps 2 to 5);

4) Consolidating new meanings. This involves the articulation of themes that were identified during treatment in a new emerging narrative about the self and the world (i.e. in the global process of narrative reorganization).

Concluding remarks

The present dissertation has several limitations that we would like to acknowledge at this point. First, due to the small size of this sample, involving only six dyads with six clients and five therapists, we are aware that our results may not generalize to other EFT dyads. Moreover, the comparisons made between GO and PO cases, while giving very important information, represent a dichotomization of clinical reality which is certainly much more complex. Thus, it would be important to expand these studies to a larger sample of dyads and EFT cases.

Additionally, the fact that we worked only with therapy transcripts with minimal access to the visualization of therapy videos limited the scope of these analyses, since they relied mainly on verbal interaction. It would also be interesting to replicate these studies with the access to therapy videos of EFT cases to see if additional adjustments need to be pursued and if the current findings are confirmed or challenged.

Nevertheless, this dissertation uses different theoretical approaches and research methods to investigate a coherent set of questions, arriving at consistent results across studies and building upon them from one study to the next. In particular, it allowed understanding in more detail the notion of reconceptualization and the importance that these narratives about *the self in transformation* have in the development of good outcome therapy and narrative change in EFT. We suggested that the recursivity and repetition of reconceptualization IMs serves important developmental functions (Gonçalves & Ribeiro, in press): (a) the restoration of a new sense of continuity in the self (chapters II and V), (b) the resolution of ambivalence and uncertainty regarding the change process (chapters II and III), (c) the progressive assimilation and integration of problematic experiences (chapter IV), and (d) a renewed sense of authorship and agency in clients (chapter II and V). We detailed the steps involved in the consolidation of

reconceptualization IMs, taking part in the process of narrative reorganization that ultimately leads to the renewal of self-narratives in EFT (chapter V).

In addition, this work represents an important contribution to the understanding of the role EFT therapists play in the facilitation of client narrative changes, along with the dyadic steps that must be accomplished for the narrative reorganization of the self in this therapeutic modality. We highlight some important therapeutic strategies, such as: (i) the therapists' use of interventions focused on the exploration (of problems or change) and the promotion of (experiential) insight (chapter I), (ii) the role of client validation and support in EFT (chapters II and V), and (iii) the development of a meta-perspective stance in clients (chapters II, III and V).

To conclude this work, we would now like to look ahead into future research developments. We will start with the research developments regarding the last study (presented in chapter V): the task-analysis of narrative reorganization. First, a validation study should be pursued to investigate if this preliminary model generalizes to other EFT cases of depression. In this development, it would be important to see if the analysis of video-recorded sessions with other dyads would lead to refinements in the rational-empirical model of narrative reorganization that was presented before in the context of EFT for depression. Second, we do not know if the findings from such context would replicate with other samples of client problems (e.g. anxiety or trauma) and other forms of therapy (e.g. narrative therapy, cognitive-behavioural therapy); therefore, we should explore the task of narrative reorganization in these contexts (and arrive at specific task-analytic models). Up until now, the research on IMs has been obtaining the same pattern of results in different client samples and therapy modalities (Alves et al., 2011; Gonçalves et al., 2010; Gonçalves, Mendes et al., 2011; Matos et al., 2009), which makes this replication even more appealing. Third, another possible line of development would be to incorporate this knowledge about narrative change in the practice and training of EFT. Recently, the current efforts to integrate narrative work in EFT have been pursued by key authors in this field (see Angus & Greenberg, 2011); however, there is the need to further clarify how this knowledge can be put into EFT practice.

Another interesting research development would be to pursue additional analysis of helping skills in other client samples and therapeutic modalities. This would allow the

contrast with other contexts besides EFT and clarify which skills may be particularly productive for narrative change across modalities and what features are specific to EFT for depression. Furthermore, the intensive analysis of these cases with more sophisticated methods, such as *state-space grids* (e.g. Ribeiro, et al., 2011), would allow to expand the sequential analysis of therapist skills and client IMs beyond lag 0, arriving at a more detailed picture of the developmental effect of the interplay between therapist interventions and client IMs.

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